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Exploring The Experiences Of African American Nurses: An Emancipatory Inquiry

Laurie Pierce

EXPLORING THE EXPERIENCES OF AFRICAN AMERICAN NURSES:
AN EMANCIPATORY INQUIRY

by

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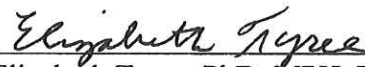
This dissertation, submitted by Laurie Pierce in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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July 24, 2018
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Date

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PERMISSION

Title   Exploring the Experiences of African American Nurses: An
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                                                   Laurie Pierce

                                                   July 8, 2018

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To Dennis who supported me.

To Dad who encouraged me.

To Mom who taught me that traveling the unknown road is always the

most interesting and rewarding.

ABSTRACT

This inquiry provided a critical and in-depth analysis of African American nurses'

situations within the context of the work environment. Through this examination,

multiple oppressions were illuminated. Participants identified both personal experiences

of oppression and oppression related to administrative and interdisciplinary hierarchies.

Additionally, the participants provided their insights on the concept of empowerment.

Definitions of empowerment included being a voice for self and others and empowering

others is empowering to self. Thus, the concept of relational empowerment was

explicated. Furthermore, the participants envisioned an ideal environment where

administration is supportive of nurses, nurses have time to care for the patients, and the

interdisciplinary team have open communication that allowed for holistic care of patients.

The participants envisioned an ideal work environment where nurses' voices were heard,

and nurses had an active role in the development of policies and participated in staffing

decisions. Open communication within the interdisciplinary team and respect from team

members was emphasized. Lateral violence and incivility were eliminated in the

participants' ideal work environment. Finally, to align with the constructs of

emancipatory research, praxis occurred through a discussion of how the participants

conceived of creating change within the work environment.

CHAPTER I

INTRODUCTION

Chapter One presents an introduction and overview of this study, exploring the African American nurses' professional experiences within the context of the healthcare environment. The significance of the study and contributions to nursing knowledge are described. The method of the study is briefly introduced with a thorough explanation of methodology given in Chapter Three.

Background

The United States population is growing increasingly diverse. The United States Census Bureau (United States Department of Commerce [USDC], 2017) reported that 13.3% of the United States population is African American. Additionally, the population is also aging as the United States Agency on Aging (2013) estimates that by 2050, 11 % of the population over the age of 65 will be African American. The change in population will represent a 104% increase from 2013. The American Association of Colleges of Nursing (AACN) (2015) asserted that a diverse nursing workforce would better serve the needs of the growing and diverse population. To that end, efforts to increase a diverse workforce have focused on improving access to nursing education.

Multiagency strategies have increased the diversity of students entering nursing programs. Efforts to improve the diversity of the nursing workforce demonstrated an

increase of African American nurses from 4% in 1910 to 11.5% in 2015 (D'Antonio &

Whelan, 2009; National Council of State Boards of Nursing, 2016; USDC, 2017).

However, the nursing shortage will also be reflected in the African American population.

The shortage of African American nurses will be compounded by the current wave of

baby boomer retirements and nurse retirements (American Association of Colleges of

Nursing [AACN], 2012). Additionally, since the implementation of the Affordable Care

Act (ACA), approximately 20 million more people have sought primary and preventative

services, requiring more nurses to provide care to an already aging population (Lathrop,

& Hodnicki, 2014; USDC, 2017). Therefore, the nursing profession must develop

effective strategies to recruit and retain African American nurses, which may improve the

health of diverse and vulnerable populations and decrease health disparities (AACN,

2015; Phillips & Malone, 2014).

Ethnic Congruence of Healthcare Providers

The purpose of recruiting and retaining African American nurses is to promote

health equity. Ethnically congruent healthcare providers may improve care to diverse

and vulnerable populations (Corrigan et al, 2017; Institute of Medicine [IOM], 2010;

Sullivan, 2004). Sullivan (2013) asserted that racial and ethnic minority health

professionals from socioeconomically disadvantaged backgrounds are more likely to

serve others of similar backgrounds. Ethnically congruent healthcare providers engender

vulnerable persons' trust in the healthcare system (Phillips & Malone, 2014; Smith, 1999,

2005; Sullivan, 2004). Furthermore, African American health professionals are more

likely than Caucasian providers to recognize barriers to health equity as a function of the

healthcare system. Diverse providers recognize inequity arises from limited access to

care versus behaviors of the patient (Phillips & Malone, 2014; Poma, 2017; Shen et al, 2018). Thus, by increasing the numbers of culturally congruent providers, healthcare may be improved.

Multiple agencies assert that ethnically congruent nurses improve care to diverse populations. The Institute of Medicine's Future of Nursing Report (2010) affirmed that the demographic characteristics of the nursing workforce should more closely reflect that of the population to improve communication and provide "culturally relevant care" (p. 128). Additionally, ethnically diverse health professionals are more likely to advocate for policies and programs that improve access to quality healthcare services for vulnerable populations, thereby decreasing health disparities (United States Department of Health and Human Services Offices of Minority Health, n.d.; Frankel, McGuire, Zaslavasky, Lafata, & Tai-Seale, 2017; Smith, 1999, 2005, 2015). An overview of the historic position of African American healthcare practitioners support these assertions.

Historically, African American healthcare practitioners were advocates for their communities and developed a following of patients who trusted them (Smith, 1999). African American physicians and dentists became leaders in their community, and nurses were perceived as competent and responsive to needs of the segregated African American population (Dittmer, 2017; Smith, 1999). VanderWielen et al (2015) and Tuazon (2010) suggested that these leadership roles continue and that health care providers who live and work in underserved communities can reduce disparities in vulnerable populations. Thus, agencies must develop strategies to increase the diversity of the healthcare workforce.

Problem Statement

Efforts to recruit and retain diverse healthcare professionals have largely been unsuccessful (AACN, 2017; Phillips, & Malone, 2014; Sullivan, 2013). Strategies to increase the number of African American registered nurses focus on access to nursing programs and success in the educational process. Strategies include scholarships for ethnic minority undergraduate and graduate students, academic support of students during undergraduate and graduate programs, and mentorship for diverse students and faculty (AACN, 2015). These strategies are fully supported by national organizations; however, the strategies are limited to educational settings and do not address issues faced by African American nurses currently engaged in clinical practice. These issues include racism, work satisfaction, and limited avenues to leadership positions.

There is a paucity of research, policies, or white papers that specifically address retention, work satisfaction, or empowerment of African American nurses within the healthcare environment. Lack of empowerment and oppression of nurses negatively impacts nurse satisfaction and increases the propensity of nurses' intent to leave the profession (Adriaenssens, Hamelink, & Bogaert, 2017). Conversely, empowerment of nurses may improve work satisfaction of the nursing workforce, thereby supporting retention efforts (Goedhart & van Oostveen, & Vermeulen, 2017; Ibrahim, El-Magd, & Sayed, 2014; Manojlovich, 2007). Although there is a growing body of literature that addresses nurse empowerment, there is a paucity of literature that explicates empowerment of African American nurses. Additionally, there is a lack of information regarding African American nurse work satisfaction or intent to leave the profession.

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A search of the Department of Health and Human Resources, the Department of Minority Health, the National Council of State Boards of Nursing, the American Nurses Association, and the National Black Nurses Association websites revealed no national data demonstrating African American nurses' intent to leave the profession or information regarding those who have already left the profession. Sasaki and Vorauer (2013) suggested that a lack of information may promote inequity in healthcare and inhibit retention strategies. The omission of this information may be indicative of the larger issue of institutional racism that sustains unequal power structures or cultural blindness that ignores the impact of ethnicity and culture on well-being. To counteract a systemic lack of cultural awareness in healthcare, efforts have been made to infuse cultural awareness and cultural competency into healthcare settings and, specifically, the profession of nursing.

Cultural awareness and cultural competency strategies concentrate on improving nursing care to diverse clients but do not address culture-specific strategies that may improve the work environment for African American nurses (Narayan, 1998). The AACN (2017) and the National League for Nursing (NLN) (2015) recommend infusing cultural competencies into undergraduate and graduate curricula. However, there is a lack of research that specifically addresses empowerment of African American nurses and that examines unequal power structures that may support overt and covert racism as well as disenfranchisement of African American nurses.

Empowerment is an active process. For African American nurses to empower themselves, research activities and strategy development must be a collaborative effort between researchers and participants (Ledwith, & Springett, 2010; Wall, 2010). The

researcher cannot inform the participants; the participants must enlighten the researcher. The process of change and empowerment begins through reflection and questioning the status quo (Ledwith, & Springett, 2010). The existing literature did not include an examination of empowerment of African American nurses, nor was there collaboration between researchers and African American nurses that assist in the process of improving the circumstances of African American nurses within the context of the healthcare work environment. Thus, this inquiry seeks to fill the gap in the literature.

Purpose Statement

The purpose of this emancipatory inquiry was to explore African American nurses' professional experiences within the context of the healthcare environment. The phenomenon under study was empowerment as defined by Chinn and Kramer (2011). Empowerment within the context of this inquiry was defined as a process and entails a critical examination of unequal power structures that oppress a disenfranchised group and allow their voices to be heard. Thus, the research questions were developed to meet the purpose of the inquiry and explore the phenomenon under study.

Research Questions

The research questions were designed to fulfill the purpose of this inquiry. Additionally, to investigate the phenomenon, barriers to empowerment, as hegemonic structures were explicated through the full exploration of the subsequent research questions:

1. What is it like to be an African American nurse in a predominantly White profession?
2. What are African American nurses' subjective experiences of empowerment?
3. What are African American nurses' visions of an ideal work environment?

4. How do African American nurses conceive creating change within the work environment?

<div align="center">**Significance**</div>

The significance of this study includes defining African American nurses' meanings of empowerment within the context of the work environment, identifying unequal power structures that contribute to oppression, and envisioning the creation of change within the work environment. These implications are congruent with the Chinn and Kramer's (2011) concept of emancipatory knowing. The emancipatory inquiry contributed to nursing knowledge, specifically, emancipatory nursing knowledge, which unites Carper's (1978) original fundamental patterns of knowing in nursing (Chinn & Kramer, 2011). Fundamental patterns of knowing in nursing provide a framework categorizing nursing knowledge.

Expanding Nursing Knowledge

Carper's (1978) seminal work, explicating fundamental patterns of knowing in nursing, provides an epistemological framework for describing and advancing the scope of nursing knowledge. The four fundamental patterns of knowing include empirics, personal knowledge, ethics, and esthetic knowing. Empirical knowledge is factual, unbiased, research-based, able to be replicated by others, and provides the foundation of evidence-based practice (Chinn & Kramer, 2011). Personal knowing represents a measure of self-knowledge, awareness, and self-responsibility (Clements & Averill, 2004). Personal knowledge refers to the interpersonal process between each individual client and nurse. Ethical knowing is the moral component of nursing. The nurse questions what is right and good as well as determines the course of actions for the best

outcome. Esthetic knowing is the art of nursing and focuses on ethics, intuition, and

understanding (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001). Esthetic

knowing is exploration of an action, experience, statement, or behavior and examines the

fundamental question of "what does this mean?" (Fawcett, Watson, Neuman, Walker, &

Fitzpatrick, 2001, p. 127). Each pattern is separate and addresses different aspects of

nursing knowledge. Viewing each pattern separately dismisses the whole of nursing

knowledge and reduces it to its parts. Chinn and Kramer (2011) suggested that this

separation leads to "patterns gone wild" (Chinn & Kramer, 2011, p. 18). Thus, to

promote cohesiveness of the patterns of knowing, an overarching pattern of knowing was

proposed by Chinn and Kramer (2011).

     Emancipatory knowing. Emancipatory knowing is the overarching pattern of

knowing that provides structure to Carper's original tenets. Chinn and Kramer (2011)

developed the concept of emancipatory knowing in response to the dichotomy of the

original patterns of knowing. Emancipatory knowing is the underpinning of all the

patterns of knowing as it creates a holistic view of an experience by incorporating all the

patterns, thereby generating integrated nursing knowledge. The outcome of

emancipatory knowing is transformation of people's lives through an awareness of the

existent holistic pattern. Emancipatory knowing is the reflection and examination of

social, cultural, and political injustices and how they came to exist. Four assumptions of

emancipatory knowing include (a) there is no ahistorical, value-neutral knowledge; (b)

research is a political activity; (c) power relations inform knowledge development; and

(d) social oppressions are not natural or fixed. Chinn and Kramer's (2011) emancipatory

knowing is founded on Freire's liberation theory (1970) and Habermas' critical social

theory (1973, 1979) that will be described in detail in Chapter Three. Emancipatory knowing can be created and developed through emancipatory research methods.

This study contributed to emancipatory nursing knowledge through an examination of unequal power structures that influence nurse empowerment, experienced and described by African American nurses within the healthcare environment. The participants were active in imagining the creation of change within the work environment. Within the constructs of the emancipatory method, the nurses identified their personal definition of empowerment and described experiences of empowerment. Barriers to empowerment were elicited. The ability of the African American nurses to create social change within the context of their future work environment is congruent with the Cowling, Chinn, and Hagedorn (2000, 2009) method. Thus, the findings contributed to emancipatory nursing knowledge.

Emancipatory knowing is the reflection and examination of social, cultural, and political injustices and how they came to exist. Therefore, an examination of historical and current health disparities of the African American population within the healthcare system will be presented in Chapter Two. Additionally, a historical examination of African American nursing is presented in the literature review and will be reflected in data analysis. Finally, conceptual definitions provide clarity to the framework of this inquiry.

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Conceptual Definitions

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Critical Theory: Critical theory supports the examination of hegemony and includes a historical critique of how the power imbalance developed (Agger, 1991).

Racial Discrimination: Racial discrimination is the differential treatment based on race that disadvantages a racial group (Sullivan, 2004).

Hegemony: Hegemony is the process by which unequal power is maintained and thus becomes a part of the unexamined social constructs (Chinn, & Kramer, 2011).

Empowerment: Empowerment is a process that occurs through a critical examination of unequal power structures and hegemonic practices, oppressed or disenfranchised groups may have their voices heard and will ultimately "claim their full human potential" (Chinn, & Kramer, 2011, p.84).

Healthcare setting: The healthcare setting is any environment in which healthcare is delivered and registered nurses are employed. These settings may include, but are not limited to, acute care, rehabilitation, long term care, outpatient settings, and population-based practice. (Centers for Disease Control, 2018).

Culture: "Culture is a pattern of commonly shared beliefs and behaviors, including styles of communication; ways of interacting; views on roles and relationships; and normative values, practices, and customs" (Sullivan, 2004, p. 16).

Critical Dialogue: A dialogue with the purpose of recognizing and critiquing practices and structures that cultivate oppressive paradigms and sustain inequalities. The dialogue presumes care and respect between participants and a questioning of what each person knows, thereby creating new knowledge and paradigms (Freire, 1970).

Feminism: The advocacy for women's economic, social, and political equal rights (Webb, 1993).

Critical Praxis: Critical praxis occurs through the practice of emancipatory research whereby hegemonic structures are illuminated, and oppressive paradigms are challenged (Cowling, Chinn, & Hagedorn, 2000, 2009; Webb, 1993).

Conclusion

Efforts to increase presence of African Americans in nursing have largely been unsuccessful. Strategies have focused on recruitment into the profession. Although there is a substantial body of work describing strategies, which advance nurses' empowerment, there is a paucity of research that explicates empowerment of African American nurses. The findings of the study contribute to filling the gap in literature related to the phenomenon of empowerment through an exploration of African American nurses' experiences within the work environment.

CHAPTER II

REVIEW OF THE LITERATURE

Chapter Two presents the extant literature on the topic and gaps therein. A historical overview of African American nursing is also presented. Literature pertaining to oppression and empowerment in the profession of nursing are reviewed. Specifically, nurses' perceptions of empowerment and psychological, organizational structures, and critical social theory components of empowerment are reviewed.

Culturally congruent healthcare providers may improve the health of diverse and vulnerable populations. Sullivan (2004) asserted that there is a direct link between poor health outcomes for minorities and a shortage of minority healthcare providers, including physicians, dentists and nurses. The shortage of African American healthcare providers is increasing as the African American population is expected to grow to 14.7% of the total population by 2060 (United States Department of Commerce, 2013) without a corresponding increase of African American healthcare providers (Sullivan, 2013). Strategies to increase the number of diverse providers has focused on access to education.

Although increasing access to education for African Americans lays the foundation for increasing diversity in the health professions, Sullivan (2013) asserted that current providers must be retained as they provide mentorship and leadership to future generations. Thus, the link between racial and ethnic disparities in healthcare and disparities in health outcomes, including disability and premature death, may be

addressed by attending to the shortage of under- represented providers, specifically

African American nurses. Nurse retention and satisfaction is directly related to nurses'

empowerment (Boormann & Abrahamson, 2014; Manojlovich, 2007; Rodwell, Brunetto,

Demir, Shacklock, & Farr-Wharton, 2014; Wong and Laschinger, 2013). However, there

is a significant gap in the literature that addresses the processes of empowerment of

African American nurses.

 The topics and literature chosen for the review support a critical analysis of the

current state of African American nurses, including a historical overview of African

American women in nursing. An examination of the literature related to the impact of

White privilege, stereotyping, and racial assumptions on health outcomes is presented.

Health disparities are examined through a review of African American's historical and

recent experiences with the healthcare system.

 An introduction of the concept of empowerment and review of nursing

empowerment is presented. The literature review includes nurses' perceptions of

empowerment and factors relating to empowerment of nurses. These factors include

organizational structures, psychological, and critical social theory. Additionally, as these

factors do not account for the whole of nurses' experiences related to empowerment, nor

do they address experiences of African American nurses' processes of empowerment,

three emancipatory studies are presented that provide the methodological framework for

this dissertation.

White Privilege

As a Caucasian, the researcher must examine potential barriers to working with diverse participants. Specifically, White privilege must be addressed. Unexamined White privilege can lead to health disparities through stereotyping, prejudice, and structural racism (Hall & Fields, 2013). Hall and Fields (2013) defined structural racism as institutional policies and actions that create health disparities. These actions include closing of inner city healthcare and public facilities as well as segregated communities with high rates of violence. Thus, African Americans are disproportionately at risk for racial health disparities. White privilege contributes to racial health disparities and is a complex concept founded on the constructs of similar experiences based on race (Hall & Fields, 2013; Kwate & Goodman, 2014; McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014). Du Bois (1935) first described White privilege in a discussion of a "psychological wage" (DuBois, 1935, p. 700). Caucasians and African Americans worked at the same jobs for the same pay during the reconstruction era. However, Caucasians, despite their social class, were shown deference and extended privileges over the African American counterparts including admittance to schools, parks, and recreational facilities. Caucasians continued to hold authority through the courts, politics, and education. This racial bias continues and must be recognized by individuals to promote equity.

Personal observations of White privilege were further explicated in McIntosh's (1988) essay. In her seminal essay, she described uncovering her own unacknowledged conditions of privilege, specifically, daily experiences of not being judged on race. These experiences included being of a similar race to the majority and knowing that, if she had

contact with others, received a speeding ticket, was late to a meeting, or received healthcare, she was not being judged by race. She asserted that through White privilege, others are oppressed.

In an essay by Puzan (2003), White privilege is discussed within the profession of nursing. As most nurses are Caucasian, the author asserted that White privilege substantiates the authority held by the majority and that this privilege allows for the majority to establish what "counts for knowledge, membership, and language" (Puzon, 2003, p.195). Additionally, social norms and customs are determined by Caucasians, thus requiring assimilation of other cultures to the majority standards. The author asserted that science is a hegemonic domain of power. Critiquing positivist research methods, the author asserted that the current focus of science is on Western medicine, thus maintaining a homogeneous patriarchal White culture within the healthcare system. The author specifically critiqued nursing education in that "nursing faculty determine curricula and resent any outside influences" (Puzon, 2003, p. 196). Thus, faculty and students are socialized to accept the status quo without incentive to challenge authority. Finally, the author described personal experiences in nursing education both as a student and faculty member.

Puzan (2003) anecdotally described the response of nursing faculty to African American nurse practitioner students who stated that they preferred access to more diverse populations for whom they would be caring upon graduation. Faculty construed this request as a threat to their authority and stated that the African American students wanted special accommodations. Ultimately, an arbiter was hired to mediate between the faculty and the students. Many of the faculty did not attend the forums, including the

Chair of the Department. The arbiter, an African American woman did not address any racial issues within the situation, thus missing the opportunity to open a dialogue, examining hegemonic structures existing within the nursing program.

The inherent weakness of Puzan's (2003) essay is the numerous assertions made without validation or references. One of many examples of this weakness is the author's statement that "The ANA refers to great diversity among the nearly 2 million persons employed as registered nurses, as indicated by the fact that nurses come from every socioeconomic class ever stated and every neighborhood in American" (Puzan, 2003, p.195). There was no citation or reference to this assertion, thus, the reader could not evaluate this statement within the context of the entire ANA report. A second example was the statement that "Pharmaceutical companies provide another example of stratification by race, class, and nation when they deny life- saving medications that are deemed too costly or unprofitable for investment in global locations where non-White people predominate" (Puzan, 2003, p. 195). Although most likely accurate, this statement is not supported by any literature or statistics, thus making this essay an opinion editorial. However, this essay provided the basis of the dialogue that the profession of nursing, dominated by a White population, creates the hegemonic structures that disenfranchise other groups. Additionally, the author asserted, "the challenge for nursing, in all of its identities and positions, is to engage in the exposition, critique, and resistance needed to dismantle the structural and functional representations of unbearable Whiteness" (Puzan, 2003, p. 196).

White privilege in nursing must be examined and addressed. White privilege contributes to the authority of the dominant culture and maintains a hierarchy of power

(Allen, 2006). Thus, through a hierarchal social structure, Whiteness implies a higher

social status (Kwate & Goodman, 2014). The unequal structure of power reinforces the

unequal distribution of privileges and resources (Schroeder & DiAngelo, 2010). These

unequal power structures are "historically, socially, politically, and culturally produced"

(p.245). The benefit of maintaining the higher social status and White privilege is that

there is a freedom from being viewed through a racist lens (Hall & Fields, 2013).

Although the White person may be against racism, the person still benefits from the

higher social status (Schroeder & DiAngelo, 2010). The hierarchal status and unequal

power structures may negatively impact African American nurses' advancement within

the leadership structure, diminish empowerment, and decrease work satisfaction.

Additionally, continuous exposure to overt and covert racism may negatively impact

physical and mental health.

Consistently being viewed by race has harmful health effects and may be

psychologically draining (Kwate & Goodman, 2014; Wing, Lin, Torino, Capodilupo, &

Rivera, 2009). The harmful health effects of racial assumptions on pain management in

African Americans were verified by Trawalter, Hoffman, and Waytz (2012). Inequitable

treatment of health issues leads to negative patient outcomes.

In a quantitative study, conducted at the University of Virginia, the researchers

demonstrated that the participants that included Registered Nurses (n=29) and nursing

students (n=14), all but one of whom were Caucasian, assumed a priori that African

Americans feel less pain than Caucasians (Trawalter, Hoffman, & Waytz, 2012). The

well-designed study may have been strengthened by a qualitative component of a

description of the participants' individual perceptions of their assessment of pain.

Additionally, there was no stratification of experience within the profession that may influence assessment of pain. However, as nurses have the primary responsibility for pain management, implications of these findings contribute to the assumption that being viewed by race has deleterious health outcomes. Further exploration of the beliefs of the nurses, through qualitative means, may explicate the underlying beliefs held by the nurses.

Perceived inequity in economic and social status in addition to culture may also negatively impact health outcomes. Kwate and Goodman (2014) investigated the relationship between White privilege and health outcomes. The relationship was measured through perceptions of inequality and subjective and objective social status and how those perceptions affected the health and well-being of the participant. A random sample of Caucasian participants (n=620) was chosen from three Boston neighborhoods. The participants included those from a higher standing, within the social hierarchy, who lived in predominately Caucasian neighborhoods and those from a lower social standing who lived in poorer, more racially diverse neighborhoods. Questionnaires included information on self-rated health outcomes of physical health, dental health, and happiness. The investigators concluded that objective measures of socioeconomic status were associated with better health outcomes for individual level factors; however, subjective assessments of social position were most strongly associated with self-reported health outcomes. Participants with the highest self-reported health status lived in the wealthier neighborhoods. These participants described their neighborhoods as welcoming to African Americans with minimal racist tendencies. Participants, who lived in the neighborhoods with the least wealth and most diversity, reported poorer health

outcomes. These participants reported that their neighborhoods were not welcoming to African Americans. The findings support the supposition that White privilege exists within a social hierarchy and that exposure to racism may impact the health of populations despite ethnicity or race.

The strength of this quantitative study included random sampling and a well-designed study. The limit of this study included a potential lack of power for statistical modeling and self-reports of health and well-being. The researchers also do not describe why the participants had poorer health; therefore, a qualitative inquiry may aid in filling that gap. Additionally, this study was conducted in Boston, a few days after the Boston marathon bombing. This event may have altered self-reports of health and well- being and may be considered an external threat to validity.

Perceived racial privilege and exposure to racism may also affect health and well-being. Fujishiro (2009) explored the correlation between racial privilege and exposure to racism with the health and well- being of Caucasian and African American participants (n= 22,412). Caucasians who reported being aware of their position of racial privilege and exposure to racism reported significantly higher rates of poorer health and missed work days than those who did not perceive their own White privilege (OR=1.51; p<.05). The researcher asserted that exposure to racism impacts health and well-being despite race or ethnicity.

The strength of this study was a large sample and strong statistical modeling. The limits of the study included a random pattern of missing data related to self-reported race that may have biased the results. Additionally, the cross-sectional design limits the

generalizability of the findings. A qualitative inquiry may clarify the findings related to exposure to racism and perception of health and well-being of all populations.

Healthcare and Discrimination

A history of discriminatory laws, racial bias, and inequal access to healthcare have had a negative impact on health outcomes for African American populations. Additionally, the history of racism has created a distrust in the healthcare system. This mistrust also contributes to poor health outcomes. Thus, a review of the history of healthcare inequity must be examined.

History, Laws, and Federal Policy Initiatives Related to Healthcare

Discriminatory practices are reflected throughout the history of the United States. Prior to the Civil Rights Act of 1964, legally sanctioned discriminatory practices enforced separate but equal access to housing, schools, and healthcare (Narayan & Scafide, 2017; Reynolds, 2004; Smith, 2015). These discriminatory laws, known as Jim Crow laws, imposed separate accommodations in healthcare. In smaller communities, African Americans were cared for in basement wards or separate wings. In larger cities, African American hospitals were older buildings vacated after new facilities for Caucasian populations had been built.

Communities were also divided by race and created inequity and disparity. Although the separation of the African American community caused disparities, it also insulated the healthcare professionals and gave them freedom from White control (Smith, 1999). Sullivan (2013) asserted that this freedom provided the basis for the rise of the African American middle class. African American physicians and dentists became leaders in their community and nurses were perceived as competent and responsive to the

needs of the segregated African American population (Hine, 1988; Smith, 1999). Thus, the leadership exhibited by the African American healthcare professionals supports the assertion that culturally congruent providers will improve outcomes for diverse populations.

Although Jim Crow laws were deemed unconstitutional, resistance to desegregation continued. Despite Brown v. Board of Education and mandatory desegregation of schools in 1954, healthcare remained segregated (Reynolds, 1997). Two landmark cases, Simkins v. Moses H. Cone Memorial Hospital (1963) and Cypress v. Newport News Hospital Association (1967) provided the basis for eliminating legally sanctioned discriminatory practices in hospitals. Hospitals were required to desegregate under Title VI of the Civil Rights Act of 1964. However, a complete desegregation did not occur until the federal government threatened to discontinue Medicare funding in 1968 (Reynolds, 1997, 2004; Smith, 2005). A history of discriminatory practices impacts the health of African Americans today. The impact of discriminatory practices negatively effects health outcomes.

Effects of Discriminatory Practices on Health Outcomes

The effect of discriminatory practices influences African American populations' access to healthcare. Giger and Davidhizar (1997) asserted that African American elders do not seek healthcare due to past discriminatory practices and a lack of trust in healthcare providers. This view was supported by Shellman (2004), who asserted that a lifetime of racial segregation, poverty, and a disregard of healthcare needs have negatively impacted the health outcomes of African Americans elders. In a phenomenological inquiry, Shellman (2004) interviewed seven African American elders

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residing in the Northeast for the purpose of understanding the life experiences of the participants. Multiple themes were illuminated, including stories of discrimination, coping with discrimination, the hurt of discrimination, and themes of self-discovery.

The themes illuminated in the Shellman (2004) inquiry reflected the life history of African American elder. Stories of discrimination in healthcare included a lack of equal access to medications, seeing a provider if and when the provider chose to care for the person, walking miles to see the provider, and entering through a back door. The strength of this inquiry was a well-designed study that was credible and auditable. The limitation of this study was that findings cannot be extrapolated to a larger population. However, the findings supported the assertions that past and current discriminatory practices, a distrust in the healthcare system, and distrust in the dominant race has contributed to health disparities in the African American population (Shellman, 2004). A theme that ran through the interviews was the surprise that the African American elders felt that someone cared enough to ask them about their experiences. Asking is caring was the underlying message of this study. This assertion that has relevance for nursing practice. Additionally, ethnically congruent healthcare providers may engender trust in African American populations, specifically elders.

Health care providers who engender trust may increase healthcare seeking behaviors of patients and improve health outcomes. Ethnically congruent healthcare providers can improve care to diverse and vulnerable populations (Gates & Mark, 2012; Phillips & Malone, 2014; Sullivan, 2004). The current effects of a history of disparities and discrimination must be examined as the examination illuminates the need to improve

access and care of African American populations. Additionally, the participants of the current inquiry are a part of the larger population that faces these health inequities.

African American populations continue to experience inequities in both health outcomes and access to healthcare. Ostensibly, Title VI of the Civil Rights Act was created to provide equal access to services; however African Americans continue to experience unequal access to healthcare and significant health disparities due to the complex interaction of socio economic and environmental disadvantages (Ayalon & Gum, 2011; Carthon, 2011; Danzer, 2012; Smith, 2005, 2015; Sullivan, 2004).   African Americans under the age of 25 experience a high school non-completion rate at 17.3% compared to Caucasians at 7.3% (Centers for Disease Control Office of Minority Health, 2014). Populations who do not graduate from high school are more apt to live in poverty. Among racial and ethnic groups, African Americans have the highest rate of poverty, 28% compared to Hispanics, 26%, and Caucasians at 9.9%. African Americans experience a disproportionate unemployment rate at 11.6% compared to 7.5 % of the Caucasian population (Agency for Healthcare Research and Quality, 2013). Thus, poverty and unemployment are intertwined. Additionally, those who are unemployed do not have access to employer provided health insurance. Poverty and unemployment are also entwined with hazardous living conditions. African Americans are 1.7 times more likely to live within three kilometers of a hazardous waste facility, and have a disproportionate number of adverse health outcomes related to asthma and cancer due to environmental factors than Caucasian populations (CDC, 2013). Although cardiovascular disease is the leading cause of death within all populations, the rate of premature death in African Americans is 29 % higher than the Caucasian population from

diseases of the heart, while the rate of death from cerebral vascular accidents is 40%

higher (Agency for Healthcare Research and Quality, 2013). Therefore poverty, limited

education, inadequate access to healthcare, and harmful environmental factors lead to

poor health outcomes. Additionally, a mistrust in the healthcare system may impede care

and intensify health disparities.

Current Perceptions of the Healthcare System

Patient negative perceptions of the healthcare system may contribute to poor

health outcomes. Sullivan (2004) concluded that bias, prejudice, and stereotyping by

healthcare providers contribute to healthcare disparities. Perceived discrimination and

stress due to racism contributes to chronic stress related health disparities, poor birth

outcomes, and mental health disorders (American Psychological Association, 2014;

Beatty et al, 2011; Lyles et al, 2011). Perceived racism negatively impacts health

outcomes. In a mixed methods study, Campesino, Saenz, Choi, and Krouse (2012)

administered questionnaires to Hispanic and African American women (n=39) who had

been treated for breast cancer within six months of the study. The purpose of the study

was to examine the incidence of perceived discrimination. Interviews with the group

were also conducted. Participants perceived disrespect from providers due to the

participants' skin color and ethnicity, and that ethnicity affected their level of care (46%).

Although limited by the sample size, this inquiry described perceived discrimination in

the healthcare system based on ethnicity. Perceived discrimination can be based on

stereotype threat.

Stereotype threat may impact performance. Stereotype threat occurs when cues

within the environment create a feeling that a person is at risk for confirming a negative

stereotype concerning his social group (Steele & Aronson, 1995). Those who are stereotyped will live up to that expectation. A frequent example is the stereotype that girls do not perform well in mathematics and science. Girls may internalize this stereotype and, in fact, do not excel in those academic areas (Spencer, Steele, & Quinn, 1999). Stereotype threat based on racism is illustrated in the Steele and Aronson (1995) study where the researchers demonstrated that African American college students performed poorly on standardized tests when their race was emphasized and were more successful when race was not emphasized. Stereotype threat may lead to poor cognition and memory, anxiety, negative emotions, and feelings of disenfranchisement (Burgess, Warren, Phelan, Dovdio, & van Ryn, 2010). Stereotype threat may also impede advancement within the work environment. Additionally, stereotype threat may influence health outcomes.

Stereotyping may negatively impact health outcomes. Stereotype threat may impact the relationship between the healthcare provider and the patient, resulting in missed appointments, failure to refill prescriptions, and failure to participate in health screenings, thus leading to poor health outcomes (Campesino, Saenz, Choi, & Krouse, 2012; Chen & Yang, 2014). Although stereotype threat has been investigated in relation to healthcare and education, further research may illuminate the issues of stereotype threat, how it impacts the success of African American nurses within the healthcare system, and how the structures are maintained that allow for this threat to continue. Additionally, stereotype threat may negatively effect psychological empowerment by reducing feelings of agency or self-efficacy. Psychological empowerment will be explicated in the review of literature surrounding nurse empowerment. Stereotype threat

may also lead to feelings of distrust in the healthcare system. Mistrust in the healthcare system may lead to poor health outcomes.

Mistrust in the healthcare system is associated with under-utilization of health services, including preventative care (Laveist, Isaac, & Williams, 2009). In a random telephone survey, 327 African Americans were surveyed regarding the association of distrust in the healthcare system and utilization of healthcare services. Feelings of distrust were associated with failure to adhere to medical advice (p< .01), failure to keep a follow up appointment (p=.01), postponing receiving needed care (p=.01), and failure to fill a prescription (p=.002). The strength of this study was randomization of the participants and robust statistical modeling. However, statistical power was not reported in the analysis. The limitation of the study was the restriction of participants to one city; therefore, findings may not be transferable to other geographic areas.

Distrust in the healthcare system is widespread within the African American population. The aforementioned findings were substantiated in a quantitative study that sought to identify racial differences in healthcare system distrust (Armstrong et al, 2013). In a telephone survey, 762 African American and 1267 Caucasian adults were randomly selected and surveyed regarding their feelings of racial discrimination and distrust in the healthcare system. The researcher suggested that African American adults in this sample had a higher level of distrust in the healthcare system that was associated with experiences of discrimination. The strength of this study was the use of random sampling and a strong statistical model. However, the author identified many limitations of the study. These limitations included difficulty measuring racial discrimination and the use of a cross-sectional model that does not determine causality between feelings of racial

discrimination and distrust in the healthcare system. However, distrust in the healthcare system was substantiated in other inquiries.

Distrust in the healthcare system may contribute to poor health. The previous findings were corroborated in a quantitative study that investigated the relationship between a high distrust in the healthcare system with poor, self-rated health (Chen & Yang, 2014). Through a telephone survey of a randomly selected sample of Caucasian and African American adults (n=9880), the researchers identified that perceived discrimination against African Americans had a significant, positive association with distrust of the healthcare system (p=.001). The presentation of statistical modeling provided validation of the findings, although statistical power was not described. Limits of the study included a cross-sectional study whereby cause and effect between distrust in the healthcare system and self-rated health could not be confirmed, and self-reporting of experiences may have biased the findings. However, further inquiries validated feelings of mistrust in the healthcare system and health seeking behaviors.

In a longitudinal quantitative study from 1997 to 2003 African American women number 47,228, were surveyed every two years, reporting health screening behaviors (Mouton et al, 2010). Using a logistic regression analysis, the investigators indicated that as exposure to racism increased, participation in health screenings, including Pap smears and mammograms, decreased. The strength of this study was a robust method of data analysis and attainment of statistical power. The weakness of the study included self-reporting of perceived racism and screening behaviors that may have influenced the findings. Self-reporting in epidemiological studies may introduce systemic bias during data analysis (Baily & Handu, 2012). Memory lapses, misinterpretations, simplifying,

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and modifying answers to be considered socially acceptable, may impact the interpretation of the data. African American women have a history of experiencing racism in the healthcare system.

History of African American Women in Nursing

African American women, specifically, have experienced systematic oppression and marginalization. Until the 1970s, compulsory eugenic laws forced some African American women to undergo forced sterilizations to maintain White racial purity (Patrick, 1996). Sideshow displays of African women, called Hottentots, in the 1920s objectified the African American female body (Washington, 2008). Thus, historically African American women have faced significant oppression, sexualization, and racism. Specifically, African American nurses have experienced significant oppression through discriminatory practices in education and a lack of professional opportunities (Carnegie, 2000).

A review of the history of African American nurses demonstrates significant oppression and illuminates the careers of strong leaders. African American nursing has been practiced for centuries (Davis, 1999). On the continent of Africa, tribal medicine and herbal remedies provided the basis for healing and rudimentary practitioners were apprenticed into healing practices. In the antebellum south, female slaves worked as nurses and cared for both slaves and owners. Slave midwives were hired out to surrounding families and proved a profitable investment for the plantation owners. The household nurse, "Mammy," interacted with owners and was considered "aristocracy" of the slaves (Davis, 1999, p.5). In the free states of the North, discrimination against African Americans in general and African American women was widespread. While

travelling with families to the North, African American nurses were frequently refused service by African American waiters and bellmen. Thus, during the pre-Civil war era, African American women and nurses experienced oppression and racism.

Although African American nurses faced racism and oppression, not all were enslaved Nurses in the South, who earned their freedom, began schools of nursing and hospitals. These schools of nursing included Hampton School of Nursing in Hampton, Virginia, St. Philip's School of Nursing in Richmond, Virginia, and Lincoln Hospital and School of Nursing in Durham, North Carolina (Carnegie, 2000; Reynolds, 2001). Many of the schools closed or were subsumed by larger institutions in the 1970s. In segregated Boston, prior to the civil war, Mary Eliza Mahoney attended the New England Hospital for Women and Children, becoming the first African American professional nurse (Davis, 1999). During the civil war, Sojourner Truth, born a slave, became an abolitionist, Underground Railroad agent, and nurse (Carnegie, 2000). After emancipation, she worked with the Freedman's Bureau in Washington, D.C. as a nurse and counselor. Hence, African American nurses demonstrated courage and leadership skills.

Leadership was also demonstrated by Harriet Tubman. Although best known for her role in the Underground Railroad, former slave Harriet Tubman also served as a nurse during the civil war (Carnegie, 2000). Initially, Tubman was sent to Gullah Island in South Carolina to care for former slaves left behind when slave owners fled ahead of the Union Army invasion. Additionally, she held the position of matron nurse at the Colored Hospital, Fort Monroe, Virginia. In later years, Tubman opened her home to care for aging African Americans in Auburn, New York. Known as an abolitionist, a suffragette,

a civil war spy, teacher, and social reformer, Tubman embodied the ideal of leadership. Despite the work of Tubman and others, legally sanctioned discriminatory practices were the norm in the post-Civil War era.

Legally sanctioned discriminatory practices were evident throughout the United States. Black Codes and Jim Crow laws promoted strict patterns of segregation and discrimination of the African American population during the post reconstruction era (Carnegie, 2000; 2015). Thus, segregated diploma and baccalaureate nursing programs came into existence, financially supported by the African American communities (Carnegie, 2000; Hine, 1988; Reynolds, 2001). Lincoln Hospital's School of Nursing in Durham, North Carolina was representative of many of the segregated schools of nursing throughout the southern states (Reynolds, 2001). Although segregated, the schools offered African American women educational opportunities.

Educational opportunities within segregated schools continued through 1971. From 1903 through 1971, Lincoln Hospital provided the opportunity for education as nursing was one of the few careers available to women, and the segregated school admitted African American women (Wicker, 1994). Graduates of the program went on to be administrators, educators, and clinical practitioners. Like other segregated nursing schools, the school was closed with the last class graduating in 1971. Although these nursing schools were considered rigorous within the African American healthcare community, Caucasian nurses, physicians, and administrators considered these schools and their graduates inferior (Hine, 1988). Administrators reported that African American nurses concealed errors and were unsuited to supervisory positions in hospitals. The

opposing perceptions of the segregated nursing schools contributed to the bias against African American nurses.

Bias against African American nurses was also evident in hiring practices. During the early 20th century, many Visiting Nurse Associations refused to hire African American nurses due to the belief that these nurses were educationally inferior to Caucasian nurses (Hine, 1988). If African American nurses were hired in public health settings, they were treated as social inferiors and rarely given supervisory positions. Additionally, they were paid at a much lower salary. However, African American nurses were held in high esteem in the African American communities and, therefore, could advocate for the health of these populations. Specifically, community and public health nurses were respected by their communities and were integral in care of the populations.

Public health nurses were responsible for health of populations and engendered the trust of communities. Eunice Rivers exemplified the portrait of a "good country public health nurse " (Hine, 1988, p. 189). Graduating from the Tuskegee Institute's nursing program in 1922, Rivers was a public health nurse in rural Macon, Alabama. Providing health education for African American women, Rivers had also worked in the Bureau of Vital Statistics. The combination of exemplary public health communication skills and her background in data collection made Rivers an optimal choice for a job within the Tuskegee Syphilis Experiment.

As a public health nurse, Rivers was trusted by the community. Rivers' pivotal role in the Tuskegee Syphilis Experiment has been the topic of many ethical arguments (Kearns, 2013). Scholars view her as complicit in preventing the study participants from receiving treatment for syphilis; others view her as an African American nurse used to

complying with orders from Caucasian male physicians (Hine, 1988). The complexity of her reasons may be found within the culture of the Jim Crow south, her role as a subservient nurse and African American woman, and her role as an employee of the Public Health Service. Rivers was interviewed only once. She described herself as a public health nurse who had earned the trust of the community (Kearns, 2013). She viewed herself as caring for the sick and impoverished community and viewed the participants of the study as patients and not research subjects. Although Rivers was integral to the Tuskegee Project and was a respected public health nurse, African American nurses continued to experience bias and racism.

African American nurses faced many barriers to success. In addition to discriminatory practices within the work environment, the role of African American nurses in professional organizations was limited. The American Nurses' Association first allowed African American nurses membership in 1948 (Carnegie, 2000; Hine, 1988). State Nurses Associations in the south continued to refuse admittance of African American nurses into the organizations. Elizabeth Carnegie, Dean of Nursing Education at Florida Agricultural and Mechanical College, led the fight for admittance of African American nurses into the Florida State Nurses Association. By 1952, African American nurses attended business meetings of the Association but were still barred from the luncheon (Hine, 1988). African American nurses faced discriminatory rules and professional bias. Although able to participate in meetings, integration of professional organizations would take decades.

African American nurses did not receive full acceptance to professional organizations for many years. By 1980, all State Nurses Associations had become fully

integrated, and African American nurses became leaders within the discipline with Barbara Nichols who served as the first African American president of the American Nurses Association from 1978 through 1982 (Carnegie, 2000). Nichols was followed by Beverly Malone, as the American Nurses Association President from 1996 through 2000 who then became the first African American Chief Executive Officer of the National League for Nursing from 2007 to the present day. Malone was ranked 29th of the 100 most powerful people in healthcare by *Modern Healthcare Magazine* (National League for Nursing, 2013). Although Malone exemplifies the increasing power of nurses, specifically African American nurses within the healthcare environment, African American nurses are still members of an oppressed group. Oppressive and discriminatory practices are evidenced through adjudicated disputes.

Case Law

On July 2, 2001, Beverly Enterprises settled a United States Equal Opportunity Employment Commission (EEOC) $2.1 million racial harassment lawsuit. Nine individuals filed a complaint of violation of civil rights under Title VII of the Civil Rights Act of 1964. The nine former employees stated that the administrator of a nursing home in Bridgeton, Missouri used racial slurs, unlawful discharges, and racial harassment against the African American employees, including Registered Nurses. Unfair hiring practices were demonstrated through coding of applications where smiling faces were drawn on the applications for White applicants and faces with frowns for African American applicants (United States Equal Employment Opportunity Commission [EEOC], n.d.). The administrator's position was terminated, and Beverly Enterprises revised reporting and investigation procedures for allegations of racial discrimination. In

addition to hiring practices, civil rights violations were demonstrated in facilities' actions of managing racist patients.

In May 2005, the EEOC secured a $500,000 settlement against a nursing home in Puyallup, Washington for violation of civil rights under Title VII of the Civil Rights Act of 1964. The EEOC (n.d.) found that an all-White management team developed a care plan for a White resident in which the family's request for "no colored girls" care for the resident was documented and followed. The administration tolerated use of racial slurs, including referring to an African American nurse as a "slave." Additionally, nursing administrators assigned African American nurses to the night shift and Caucasian nurses to the day shift. One African American nurse was denied promotion to an administrative position despite years of experiences and being qualified for the job.

In December 2010, the EEOC secured monetary compensation for a violation of civil rights in assignment of home caregivers in Anne Arundel County, Maryland. The home care agency acquiesced to requests from families that African American caregivers were not to enter the homes. Patient care plans were coded by circle dots for those families who preferred Caucasian caregivers and nurses (EEOC, n.d.). In addition to a violation of civil right, facilities who acquiesced to racist patients were found to have created a discriminatory and hostile work environment.

In Chany v. Plainfield Healthcare Center (2010), the 7th Circuit Court of Appeals found that the Indiana Healthcare Center supported a discriminatory and hostile work environment. Written resident care assignments instructed the nurse aides that a patient "Prefers No Black CNAs." In Battle v. Hurley Medical Center in Detroit, Michigan (2013), the defendant, Hurley, reported that a father of a Caucasian infant requested that

no African American nurses were to care for the infant. The administration acquiesced to this demand. Ultimately, this lawsuit was settled out of court for an undisclosed monetary award.

In Harris v. The Queen's Medical Center (2018), a jury in the 1st Circuit Court of Hawaii awarded a Registered Nurse $3.8 million in punitive and personal damages after allegations of racist harassment, unfair and dangerous work assignments, and emotional distress. Allegations of abuse included a photograph of a hangman's noose on her locker. Additionally, she reported that she was given unsafe assignments in the Intensive Care Unit that violated state requirements. Finally, despite reporting multiple instances of racism to administration, threats continued.

 The anecdotal court cases exemplify the discriminatory and racist barriers that African American nurses face. These experiences may lead to feelings of disenfranchisement and powerlessness (Robinson, 2013; Wilson, 2003, 2007). Feelings of oppression, powerlessness, and disenfranchisement may lead to nurses leaving the profession. Although African American nurses experience oppression, nurses in general may be considered in an oppressed group.

Nurses as an Oppressed Group

The Centers for Disease Control (2014) identified nurses as the least powerful group in a healthcare organization and, thus, vulnerable to lateral violence, limited autonomy, and lack of representation in decision making at the administrative level. Nursing has experienced oppression and subordination forced upon the profession by the paternalistic medical model of healthcare (Roberts, 1983; Roberts, 2000). Until the 1980s, nurses would rise when a physician came to the nursing unit. Frequently nurses

would give their seats to physicians. Sokoloff (1992) described nursing as a "semi-profession" (p.8). The author characterized nurses as "handmaidens" to the medical professions and stated that nursing work "flows directly from the doctor's orders and is defined as a subordinate part of medicine" (Sokoloff, 1992, p.8). Oppression of nurses has also been reinforced through feminine and professional socialization, sexualization of nurses in popular media, and nursing education and thus must be critiqued (Price & MCGillis, 2014; Roberts, 1983, Roberts, 2000; Ten Hoeve, Jansen, & Roodbol, 2013). Thus, the hierarchy of the interdisciplinary team must be examined to illuminate oppressive mechanisms.

The characterization of nurses as an oppressed group was supported by Dubrosky (2013). As the profession of nursing is predominantly comprised of women, the act of nursing is known as women's work within a patriarchal society. Additionally, as women's work, nursing care goes largely unacknowledged. As the non-dominant group within the healthcare system, nurses also take on the character of an oppressed group with increased horizontal violence or bullying of others within the profession. This lateral violence and oppressed group behavior may impact job satisfaction and nurse retention (Roberts, DeMarco & Griffin, 2009). Lateral violence must be addressed to improve work satisfaction and improve retention.

Lateral violence negatively impacts work satisfaction. Roberts, Demarco and Griffin (2009) suggested that lateral aggression directly impacts nurse satisfaction retention and satisfaction. Sofield and Salmond (2003) validated this statement in a quantitative, descriptive correlational inquiry that examined verbal abuse of Registered Nurses, influencing intent to leave the job. The researchers used Roberts (1983) behavior

of oppressed groups as the framework for the study. In a randomized sample, the 461 registered nurses answered questionnaires regarding experiences of incidence verbal assaults, prevalence and sources of verbal abuse, and behavioral responses of verbal abuse.

A total of 91% of the respondents had experienced verbal abuse with 67% of those respondents reporting one to five incidents within the past month (Sofield & Salmond, 2003). The most common source of verbal abuse was physicians (57%), patients (56%), patients' families (56%), peers (28%), and supervisors (16%). The nurses were also asked if they had left a previous position due to verbal abuse with 13.6% replying affirmative. Additionally, participants agreed that they would leave the job due to verbal abuse, and the respondents also believed that abusive incidents increased staff turnover and that verbal abuse contributed to the nursing shortage (33.4%). The study had a strong design with a well- defined theoretical framework. The researchers, however, did not describe methods of data analysis, nor did they present any information on the data other than percentages. The inquiry may be strengthened by adding a qualitative component that explicates the nurses' experiences of abuse. As with most of the literature in this review, the researchers identified potential strategies and focused on what administration could do to alleviate verbal abuse, thereby decreasing potential for staff turnover. Nurses were not asked for potential processes that may improve their work conditions. Demographics related to ethnicity were not included in the study.

Nurses not only leave their current work place due to oppressive mechanisms, nurses leave the profession due to lateral violence. Tinsley and France (2004) conducted a phenomenological inquiry. Participants included five Caucasian female Registered

Nurses with 12 to 23 years of experience in the nursing profession were interviewed with the purpose of explicating their experiences of leaving the profession. Three structures arose including the theme of "I love it….this is what I want to do…" (Tinsley & France 2004, p.9), suffering, and exodus. The participants described episodes of nurse abuse, both from within and without the profession. Nurses reported abuse of other nurses, minimal support from the administration, and lack of equity in career advancement. The nurses reported feelings of burnout and stress with resultant physical symptoms, such as insomnia and headaches. The participants all reported that they attempted to recapture the feelings that had initially led them into the profession of nursing. Finally, the nurses described their exodus from the profession. Common catalysts for leaving the profession included long hours, mandatory overtime, and being called in on their days off. The researchers reported that the synthesis of unity within the dialogue was the phenomenon of oppression. This well-designed study included a defined theoretical framework, adherence to the constructs of the method, and resonance. The authors suggested that to improve retention of nurses, nurses must be regarded as strategic assets by the profession and the institution. Additionally, the participants in this study lacked ethnic diversity. If replicated with African American nurses, the themes may be altered as African American nurses have a long history of oppression and face barriers related to racism. A review of the literature revealed experiences of African American nurses.

An early inquiry revealed experiences of African American nurses. Goldstein (1960) described the only investigation of experiences of integration of African American nurses in hospitals. The study was conducted prior to the Civil Rights Act of 1964 in a Midwestern city between 1951 and 1952. The author suggested that the culture of the

organization and administrative support of the nurses influenced their experience of integration of African American nurses. This finding was supported by Fryer (2009). Organizational support and culture influenced African American nurses' intent to stay in the profession.

In a phenomenological inquiry conducted in Michigan, Fryer (2009) investigated reasons that African American nurses stay in the profession. The investigator interviewed African American nurses (n=20) with 15 years of experience located in Michigan. Themes of a welcoming and innovative culture within the healthcare system influenced African American nurses' satisfaction and intent to stay in the profession. Other factors included leaders allowing the nurses' autonomy to make patient care decisions, nurse leaders being flexible in meeting personal needs, salary and benefits of the nurses, appropriate patient workload, and excellence in patient care. Although the research questions included identification of possible barriers in the nurses' careers, the following question was strategies organizational leaders could take to help overcome those barriers. This inquiry did not explicate unequal power structures or processes nurses recommended for improving the work environment. The focus of the inquiry was what administration could do for African American nurses; nurses were passive participants in the inquiry. Although autonomy was mentioned in the findings, autonomy was given to the nurses by the healthcare management. Empowerment of the participants was not addressed. The theme of autonomy was congruent with the findings from a qualitative descriptive inquiry that investigated issues related to work-family conflicts occurring with African American nurses in the Southeastern United States (Gipson-Jones, 2005, 2009). Autonomy was linked to job satisfaction.

Experiences of autonomy was linked to job satisfaction. However, potential work-family conflicts may impact job satisfactions. African American nurses, who worked within the African American community, described positive experiences of autonomy; themes of intrinsic satisfaction were also revealed, when discussing caring for elder African Americans (Gipson-Jones, 2005). In a mixed method study, using a descriptive correlational design, focus groups were used to determine the association of work family conflict, job satisfaction, and psychological well-being. Additionally, the investigator sought to examine the relationship between work-family conflict and job satisfaction on psychological well-being. Instrumentation included a job satisfaction survey and midlife developmental survey.

The study sought to describe the experiences of African American nurses. Participants were African American (n=79) licensed practical nurses and registered nurses enrolled in the bachelors, masters' or doctoral programs (Gipson-Jones, 2005). The nurses described a desire for flexible self-scheduling and supportive management. The nurses reported that work-family conflict, compounded by feelings of discrimination and perceived racism, negatively impacted their job satisfaction, including unfairness in workload, pay, promotion, and scheduling. The nurses reported that spirituality was how they adapted to adverse work practices. However, upon reflection, the nurses reported that inability to care for family members would be the main reason to leave the profession. As the study used a correlational design for the quantitative method, inferences of cause and effect between the independent and dependent variables cannot be substantiated. Additionally, the participants were all students in different programs from a variety of work settings; this lack of homogeneity of the participants may

influence the interpretation of the data from focus groups as the nurses have significantly varied professional and educational experiences. The participants were all students; thus, the added stressor of school may impact both the quantitative and qualitative findings. The investigator concluded that healthcare administrators must develop family-friendly work policies and conduct cultural sensitivity training. The investigator did not ask the participants what they would suggest as processes to improve the work environment nor was there a discussion of empowerment.

Experiences of racism may also impact job satisfaction. In another phenomenological inquiry, ten nurses with varied educational and professional backgrounds were interviewed to explore the experiences of racism among African American nurses with over ten years of professional experience (Alexander -Delpech, 1997). Themes of professional and social isolation, unfair assignments, and lack of opportunity for advancement were identified. The participants identified that others perceived them as not capable due to their ethnicity and that Caucasian nurses were privileged. Although a brief history of African America nurses was presented, the investigator did not address recent or remote historical issues within the analysis. Additionally, six of the ten participants were from the Caribbean, which may have influenced their perceptions of the phenomenon. Hegemonic structures were not discussed, nor did the participants engage in processes that may improve their professional situation. The investigator did state that the participants found it "cleansing to talk about experiences" and recommended that future inquiries ask the question "what was it like to talk about your experience" (Alexander-Delpech, 1997, p. 47). This concept is congruent with Hill-Collins' (1990; 2000) assertion that through an emerging

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self-awareness, the woman recognizes power and oppression in her daily life, which leads to changed consciousness. Through self-awareness, the woman is empowered. However, experiences of racism were evident in other inquiries.

Themes of racism were identified in Wilson's (2002) phenomenological inquiry of African American nurses' experiences in Louisiana. The nurses (n=13), earning varied undergraduate degrees, participated in semi structured interviews and a focus group. The nurses reported that connecting with patients and providing holistic care were positive work experiences. Themes of spirituality and religion influencing care also were illuminated. The African American nurses did report common experiences of oppression, racism, prejudice, and discrimination from both patients and co-workers. The nurses reported a sense of having no voice and powerlessness. Although the nurses reviewed the data for accuracy, there were no recommendations by the nurses that would improve professional experiences. Additionally, while the nurses described feelings of powerlessness, there was no description or dialogue regarding empowerment nor did the nurses suggest processes that may improve the work environment. A significant weakness of this inquiry was the violation of the principles of a hermeneutic inquiry.

Wilson (2002) identified the study as interpretative hermeneutic; however, the investigator used the technique of bracketing that is incongruent with the philosophical tenets of interpretative hermeneutics. Munhall (2010) described bracketing as the "putting aside personal knowledge and biases" (Munhall, 2010, p. 219). Hermeneutic phenomenology requires the researcher to identify biases and personal history and enter the hermeneutic circle with participants for a full examination of the experience (Tufford & Newman, 2010). Thus, Wilson's own experiences as an African American nurse were

not illuminated within the final interpretation of the data. Identifying the role of the investigator within the hermeneutic circle would have strengthened the study. The theme of oppression and racism were evident in the previous studies that were conducted in the United States.

Themes of oppression, prejudice, and discrimination were similar to those illuminated in a qualitative feminist participatory inquiry conducted with Maori nurses from New Zealand (n=13) and African American nurses in the United States (n=13) (Giddings, 2005). The nurses all had at least one year of experience within the profession and had varied racial, cultural, and sexual identities. Demographics of the population were not included in the description. Life stories of all the nurses were similar. The overarching theme that illuminated hegemonic structures within the profession was of the nurses not fitting into nursing and "White nurses are good" (p. 310). This theme was supported by the theme of assumed homogeneity, serving to reinforce negative stereotypes, episodes of marginalization, pressures to conform, trying to survive by denying their cultural identity, and copying the dominant culture of Caucasian nurses. Further studies may focus on one cultural group in one geographic location to explore the phenomena in more detail.

Roberts (2000) conceptualized nurses as an oppressed and marginalized group due to the hegemonic practices of healthcare that maintain unequal status. Characteristics of oppressed group behavior included passive aggressiveness and low self-esteem due to a lack of power. Lateral violence or nurse-to-nurse bullying occurs as nurses attempt to emulate those who hold power. Power, in this instance, was defined as having control, influence, or domination over a person or group (Chandler, 1992). Nursing literature

reflects multifaceted representations and definitions of power. Other types of power

include remunerative, normative, legal, coercive, and expert (Conger & Kanugo, 1988).

Expert power in nursing has been described as having the skills and knowledge that are

useful to others (Manojlovich, 2007). Benner (2001) described the power of nurses'

caring practice. By caring for others, nurses have power. However, environmental and

institutional structures must be in place that allow for caring practices to be enacted.

Manojlovich (2007) asserted that powerless nurses are ineffective nurses and may leave

their positions or the profession. Thus, to address issues resulting from systematic

oppression of nurses, specifically African American nurses' empowerment of nurses

must be examined.

Empowerment

Multiple disciplines have varying definitions of the term empowerment.

Empowerment is a multifaceted and abstract concept that can be viewed as a process or

an outcome (Gibson, 1991). Structural empowerment theorists describe empowerment as

power given to employees by the organization (Bradbury-Jones, Sambrook, & Irvine,

2008; Conger & Kanungo, 1988; Kanter, 1993). Psychological empowerment theorists

assert that empowerment is complex and arises from internal personality traits interacting

with the environment, feelings of self-efficacy, and a process that allows individuals,

groups, or organizations to have mastery over their own affairs (Rappaport, 1987;

Spreitzer, 1996). Lastly, critical social theories of empowerment arise from Habermas,

Freire, and feminist theories whereby empowerment is a process of uncovering

hegemonic structures that oppress others (Gulbrandsen & Walsh, 2012). Manojlovich,

(2007) asserted that empowerment of nurses may arise from three components: (a) a

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workplace that has the requisite structures to promote empowerment; (b) a psychological belief in one's ability to be empowered; and (c) acknowledgement that there is power in the relationships and caring that nurses provide. Manojlovich (2007) described relationship and caring empowerment through a feminist lens. Critical social empowerment is also described within the constructs of relational empowerment. In a review of the literature related to empowerment, theoretical frameworks are separate, and the locus of control varies from internal sources to external structures. Locus of control from external sources may be found in descriptions of structural empowerment.

Structural Empowerment

A review of structural empowerment must begin with Kanter (1993). Early work in managerial empowerment theory described the process of empowerment as that of administration giving power to employees to act or make decisions (Bradbury-Jones, Sambrook, & Irvine, 2008; Conger & Kanungo, 1988). Kanter (1993) described the theory of structural empowerment as organizational structures, accessible to all employees that are necessary to empower individuals. Through these structures, the organization is effective and successful. Organizational structures include tools, information, and administrative support that increase employees' skills. Through improvement of skills and knowledge, employees will be able to make informed decisions, and the organization will benefit. Kanter (1993) posited that power arises from formal and informal sources. Formal power arises from the elements of the job. Individuals holding formal power are highly visible within the organization, have decision-making authority, and are integral to the organization. Informal power arises from social relationships and communication channels within the organization. For an

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organization to be effective and successful, leaders must promote structures that give employees access to resources that will lead to empowerment.

In addition to accessing resources and open communication, organizations must also have other processes in place to empower employees. Organizations with high empowerment structures provide employees access to advancement within the organization and opportunities to increase skills and knowledge (Kanter, 1993). Employees must have access to resources, including financial means, time, and opportunities to complete their work. Information that promotes job expertise and understanding of the policies of the organization enhances empowerment. Finally, employees must receive support that includes feedback and guidance from others within the organization. High structural empowerment is strongly associated with job satisfaction, commitment to the organization, and retention of employees (Bradbury-Jones, Sambrook, & Irvine, 2008; Conger & Kanungo, 1988; Laschinger, Finegan, Shamian, & Wilk, 2004; Laschinger, Wong, & Grau, 2013; Wong & Laschinger, 2013). Thus, organizations with high structural empowerment increase employee satisfaction. Albeit, structural empowerment places the locus of control on administrative policies and practices.

The theory of structural empowerment is dependent on the organization despite the personal characteristics of the individual. The impetus for empowering others is on the side of the organization and administration, thus the locus of control is external versus within the individual and may be the antithesis of empowerment. Freire (1970) described a powerless person as one being viewed as an object to be acted upon versus a subject in which the individual has control over his situation. Gulbrandsen and Walsh (2012)

warned that externally imposed processes may oppress the individual as the locus of control is external. To counteract the potential for oppressing individuals, the locus of control must lie within the individual. Thus, psychological empowerment theories are congruent with the definition of empowerment as the process by which people gain mastery over their own matters (Rappaport, 1987). Psychological empowerment theories move the locus of control from external sources to the individual. Thus, empowerment is based within the individual.

Psychological Empowerment

Psychological empowerment places the emphasis on an internal locus of control. Psychological empowerment is an individual's perception of themselves within the work environment (Spreitzer, 1996). Psychological empowerment is a personal attribute, based on an individual's strengths and abilities (Gibson, 1991; Manojlovich, 2007). These strengths and abilities allow the individual to cope with life events, thus promoting self-efficacy (Conger & Kanungo, 1988). Those with high psychological empowerment feel able to manage life events. Conversely, Ozer and Bandura (1990) asserted that empowerment occurs through an individual's feelings of self-efficacy. Self-efficacy is the personal belief that one can effect change or control events (Bandura, 1997). The locus of control lies within the individual not external forces. However, Spreitzer (1996) asserted that self-efficacy or personal agency is only one aspect of individual empowerment. Within the concept of psychological empowerment, separate cognitions are identified.

Four cognitions provide the foundation for psychological empowerment. These cognitions include meaning, competence, self-determination, and impact (Thomas &

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Velthouse, 1990; Spreitzer, 1996). Meaning is conceptualized as the congruency between the employee's beliefs and job requirements. Meaning arises from the fit between the individual's beliefs, values, and behaviors and the organization. Competence refers to the personal belief that one has the skills to be able to complete a task. The concept of competence is a construct of self-efficacy. Self-determination is a personal sense of choice in decision-making, thus the person has the autonomy to regulate actions. Impact is the perception that the person's actions have influence on the organization. Psychological empowerment is a process as it begins with an interaction of the person and personality traits with the work environment (Manojlovich, 2007). Interaction with personality traits and the work environment shape the four cognitions that motivate personal behavior (Spreitzer, 1996). Thus, those persons with high psychological empowerment have a strong sense of self and agency. Those persons believe in their own competence and ability to successfully complete tasks. Additionally, those with high psychological empowerment may join together to effect change.

Psychological empowerment is a complex interaction between various factors. Gibson (1991) suggested that empowerment is a synergistic interaction between people and the environment as environmental and organizational structures influence individual empowerment. Additionally, people come together to share resources and collaborate to solve problems. This attribute is intertwined with Bandura's (1997) assertion that those with a high perception of self-efficacy attract support from others and develop strong social relationships. Psychological empowerment contributes to work satisfaction, retention, and intent to stay in the place of employment and the profession (Kuokkanen, et al, 2014; Kuokkanen & Leino-Kilpi; 2001; Kuokkanen, Leino-Kilpi, & Katajisto 2002;

Manojlovich, 2007; Moores, 1993; Sparks, 2011, 2012; Spreitzer, 1996). Rappaport

(1987) asserted that empowerment is a process and a psychological construct of

individual determination over one's own circumstances and "social influence, political

power, and legal rights" (Rappaport, 1987, p. 121). Conceptualizing empowerment as a

political process is reflective of critical social theories of empowerment.

Nurses' Empowerment

A growing body of literature describes nurse empowerment and is interwoven

with nurse retention and work satisfaction. Within the literature, common themes of

empowerment arise. These themes include autonomy, access to resources, workload,

interpersonal relationships, and supportive organizational structures (D'Antonio, 2012;

Wall, 2010). Organizational structures that impact nurse satisfaction and retention

include workload and resource availability that are directly related to job strain.

Autonomy, empowerment, and control over professional practice also improves nurse

satisfaction, decreases nursing burn out, and may positively impact patient care quality

(Donahue, Piazza, Griffin, Dykes, & Fitzpatrick, 2008; Wong & Laschinger, 2013).

Interpersonal relationships, including alliances with physicians, increase nurse

satisfaction (Wong & Laschinger, 2013). Nurses who experience control over their own

work environment and clinical practice demonstrate higher satisfaction levels than those

who are dominated by others (Manojlovich, 2007). Additionally, satisfaction is related to

retention of nurses (Cohen, 2009). Thus, to improve nurse retention and increase work

satisfaction work environments must promote both structural and psychological

empowerment.

However, empowerment may not be limited to structural and psychological factors. Indeed, empowerment of nurses may arise from three factors that include organizational structure, psychological beliefs, and critical social theory (Manojilovich, 2007). Researchers, conducting inquiries of organizational structural empowerment and psychological empowerment, specifically link these variables to the outcomes of nurse satisfaction and retention (Kuokkanen & Ktajisto; 2003; Kuokkanen & Leino-Kilpi; 2001; Kuokkanen, Leino-Kilpi, & Katajisto 2002; Manojlovich, 2007). However, nurses 'individual perceptions of empowerment also contribute to the overall body of knowledge related to nurse empowerment.

Nurses' perceptions of empowerment. Nurses perceptions of empowerment must be examined. Empowerment of school nurses was explored using a grounded theory approach to the inquiry (Broussard, 2007). Ten female school nurses from the public-school system in Louisiana were interviewed. The interviews gave rise to a situation-specific theory of school nurse empowerment making a difference: the role of the school nurse in the health of children in schools. Four themes were identified that demonstrated the essence of the empowerment process. These themes included enlisting support, getting through the day, maintaining control over practice, and adjusting to challenges. The nurses enlisted support through establishing rapport with school employees and support staff, gaining trust in the community, being a part of the community, and assisting others to understand the role of the school nurse. The nurses described activities that allowed them to get through their day. These activities included being organized, maintaining a sense of humor, gaining access to resources, and understanding the school system. Nurses maintained control over practice by

collaborating with other school nurses, adjusting to lack of predictability, acquiring formal education, gaining school nurse experience, and being self-confident. Finally, adjusting to challenges, thus feeling empowered, was demonstrated through developing resiliency, diplomacy, and tenacity. These themes are reflective of psychological empowerment that include feelings of self-efficacy, strong interpersonal skills that attract support from other, and the ability to develop strong social relationships that allow for communal support (Bandura, 1997). Thus, the participants described psychological empowerment as a sources of job satisfaction. A critique of the study reveals strengths and weaknesses.

A critique of the study found multiple strengths and areas for improvement. Broussard (2007) clearly described the process of empowerment of school nurses. The description of the themes illuminated in the study was clear and use of direct quotes added credibility to the findings. The categories identified offered new insights into the topic of empowerment of school nurses. Limitations of this study include a lack of introduction in grounded theory research and no description of the software used for data analysis. The researcher described participants by nursing degree, number of schools and children served, type of school, area of the school, background of the supervisor, and location of the school nurses' office. Explicating age, ethnicity, and years of nursing experience would have strengthened the findings of this inquiry as attributes of empowerment may be influenced by these variables. Specifically, ethnicity could be examined as this inquiry occurred in Louisiana, which has a large African American population. Additionally, the author did not identify limitations of this study. Future research of this situation-specific theory may focus on specific groups of nurses that

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delineate age, ethnicity, and experience. Experiences of empowerment were also investigated in Ireland.

Conceptualization of empowerment was illuminated in a qualitative inquiry of Irish nurses' and midwives understanding and experiences of empowerment (Corbally, Scott, Mathews, Gabhann, & Murphy, 2007). Ten focus groups, numbering 93 participants, were held throughout Ireland. Nurses were asked about their understanding of the term empowerment, examples of empowerment in their practice, and what enhances or inhibits empowerment. When responding to understanding of the term *empowerment,* the participants identified issues related to ambiguity of the term, organizational aspects, workplace and personal power, and practice. Their experiences of empowerment included organizational factors, management structures, professional and interpersonal issues, and the historical legacy of nurses. The participants referred to three areas when discussing their experiences of empowerment. These three areas included professional respect, personal power, and control. Professional respect was being valued by physicians, managers, and the public. The researchers identified that this theme was not described as a major theme in previous literature.

In addition, the participants identified that personal power was related to the nurse's intrinsic motivation and was illustrated in feelings of self-efficacy beliefs and self-esteem (Corbally, Scott, Mathews, Gabhann, & Murphy, 2007). The nurses reported that having a perception or sense of control significantly contributed to a greater sense of empowerment. This level of control was discussed through amount of workplace power through organizational structures, and thus, this theme of empowerment was external to the nurses. One theme was consistently identified through all focus groups. The theme

education for practice was an antecedent to empowerment versus inherent to empowerment. The participants perceived that nurses must have ongoing education to become empowered. The importance of ongoing education is congruent with the concept of expert power, whereby those who have knowledge hold power. Although there was no theoretical framework or specific methodology identified for this qualitative inquiry, the researchers clearly identified the themes in focus groups. This inquiry was conducted in Ireland, and therefore, the findings may not be transferable to other countries or cultures. Additionally, the participants were both nurses and midwives who have differing educational backgrounds, work environments, and responsibilities. The authors did not identify gender of participants, which may have influenced the results of this study. The study may be strengthened by increasing homogeneity of the participants and identifying a specific theory and qualitative method to provide a framework for the study. Further studies explicated nurses' perceptions of empowerment.

Perceptions of empowerment were illuminated in an exploratory mixed methods study. Caucasian home healthcare nurses (n=15) described their perceptions of empowerment (Williamson, 2005, 2007). Using open-ended interview questions, the nurses were asked their definition of empowerment. The abstract identified the nurses' definition of being empowered as independent, confident, trusting, and comfortable with providing quality care. The nurses' definitions within the article were vague and included statements regarding the nurse's ability to empower patients and families, working together with others, and home care, itself, as empowering. The individual statements of the participants are congruent with Benner's (2001) description of caring practices of nurses who empower patients. All the nurses identified themselves as

empowered. The nurses described empowerment as their independence of practice in interactions with physicians, coordination of care for the clients and families, and continuing education was necessary for gaining more knowledge. The nurses agreed that expert knowledge was necessary for empowerment.

The inquiry also included a quantitative component. The same participants also completed a survey that measured components of personal empowerment (Williamson, 2005, 2007). The nurses all perceived their empowerment as strong. The study did not identify organizational structures impacting nurses' empowerment. The limitation of this study was the vague definition of empowerment within the article compared with a specific definition of empowerment in the abstract. This dichotomy may be inherent of the open-ended format of the questions that does not allow for a precise answer to a question. Additionally, the format of the article was not clear, as the themes with substantiating evidence were not highlighted and provided minimal resonance within the findings. The author did not describe questions in the empowerment survey, nor was there an expanded discussion of the survey as a method of triangulation of the qualitative themes. Using semi-structured questions or providing more direction to the participants during the interview process may strengthen the inquiry. Finally, highlighting themes within the text, using direct quote and supporting evidence from the quantitative survey, may increase readability. This study did not identify organizational structures that promote empowerment. However, the literature does reveal the impact of organizational structures on nurse empowerment.

Organizational structures and empowerment within nursing. Congruent with early work in organizational empowerment theory, structures in the environment must be

conducive for employees to be empowered. Wong and Laschinger (2013) investigated

the link between empowerment and leadership style. In a random survey, nurses (n=600)

were asked to describe leadership styles, work effectiveness, and work satisfaction.

Autonomy, empowerment, and control over professional practice improved nurse

satisfaction, decreased nursing burn out, and impacted patient care quality. Workload

and resource availability were directly related to job strain. Interpersonal relationships,

including alliances with physicians, increased nurse satisfaction. Leadership traits that

promoted empowerment of nurses included transparency, high ethical standards, and self-

awareness. The authors described the statistical analysis in detail; however, power was

not addressed. Additionally, the demographic variable of ethnicity was not collected and,

therefore, not addressed in the statistical analysis. As study participants were Canadian

nurses, results may not be generalizable to the United States. However, empowerment

was significantly linked to satisfaction within the work environment.

Leaders within the work environment directly impact staff satisfaction and nurse

empowerment. Transformational leadership styles in nurse managers are linked to

empowering nurses and improving staff nurse satisfaction (Boormann & Abrahamson,

2014). Conversely, intention to quit and job dissatisfaction may be influenced by abusive

supervisory styles, including unfair task assignments, isolation, and personal attacks

(Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2014).

The assertion that abusive supervisory styles lead to intention to quit and job

dissatisfaction was illustrated in a quantitative study.   In a cross-sectional survey, nurses

(n=250) completed a survey designed to discover the link between abusive supervisor

styles and nurse satisfaction (Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton,

2014). Nurses who reported experiencing abusive supervision reported personal and health impacts as well as impaired function and satisfaction in the work place. The strength of this study was the description of power and a robust statistical analysis. The limits of the study included a cross-sectional design that does not imply causation between the independent and dependent variables. Furthermore, self-selection of participants may have led to bias and influenced the findings. Ethnicity of the participants was not addressed as a variable, thus not accounted for in the final analysis.

Structural empowerment can be linked to nurse satisfaction. The previous findings were supported by a cross-sectional, correlational study, using questionnaires that measured the association between empowerment structures and nurses' experiences of emotional exhaustion (Wang, Kunaviktikul, & Wichaikhum, 2013). A random sample of nurses (n=385) from the People's Republic of China participated in the survey. The investigators reported that there was a strong correlation between low empowerment structures and high burnout rates. Higher empowerment structures correlated to feelings of personal accomplishment. High empowerment structures and feelings of personal accomplishment contributed to nurse satisfaction. Results were compared to previous studies that demonstrated feelings of empowerment were lower than those in other countries. This finding is not surprising as empowerment is an emerging concept in the Chinese healthcare system. However, simply conducting the research in China and asking questions related to the well-being of nurses demonstrated the importance of empowerment of nurses. Job satisfaction and intent to leave organization may be influenced by feelings of empowerment.

Perceptions of high empowerment are linked to nurse retention. In a quantitative, non-experimental predictive study, Larrabee, Janney, Ostrow, Withrow, Hobbs, and Burrant (2003) evaluated predictors of job satisfaction and intention to leave. Using a survey method of data collection, the researchers suggested that nurses (n=90) with feelings of high empowerment were 2.4 times more likely to state that they had no intention of leaving their current job. Additionally, nurses indicated that low job satisfaction was significantly more likely to state an intention to leave their current job (p<.0001). Job satisfaction was significantly associated with empowerment (p<.0001). However, the study was limited by a convenience sample within a small geographic area that may bias results and limit transferability. Ethnicity was not included in the demographic information, therefore, not addressed as an independent variable in the analysis.

The positive effects of empowerment on nurse satisfaction and intent to stay was described in a quantitative study. Breau and Rheaume (2014) characterized empowerment as opportunities for advancement and access to information, support, and resources. In the study, intensive care unit nurses (n=533) responded to an online questionnaire that measured structural empowerment, work environment, and nurse satisfaction. Nurses who had greater access to structural empowerment opportunities reported a healthier work environment and higher levels of satisfaction. Additionally, nurse satisfaction, due to empowerment, had a high correlation with intent to stay in the position. The strength of this study included a large sample and a robust statistical analysis model. The limits of the study included a cross sectional design that did not allow for causal explanations. Additionally, varying hospital and management structures,

convenience sampling, and self- selection bias may have influenced the findings. Ethnicity was not included in the demographic information, therefore, not addressed in the analysis.

The concept of empowering nurses to promote retention was supported by Zurmehly, Martin, and Fitzpatrick (2009). In a web based, correlational, descriptive study was conducted with Registered Nurses (n=1335), designed to measure the correlation between perceived levels of empowerment and intent to leave their current position and intent to leave the profession. The researchers suggested that empowerment was strongly associated with intent to leave the current position (p<.0001) and intent to leave the profession (p=.0001). The strong research design, number of respondents who constituted power, and a robust statistical model lend credence to the findings. However, the findings may be biased due to self-selection and a convenience sample of a population. Participants were limited to western Ohio nurses that may limit transferability. Furthermore, ethnicity was not included in the demographic information, therefore, not addressed in the analysis.

Research, related to organizational and structural empowerment, focused on homogeneous populations or information related to ethnicity was omitted. All the studies were quantitative designs, and participants were passive, both in the process of research and in the process of empowerment. Including ethnically diverse nurses and adding a qualitative component to fully explore the concepts of empowerment of African American nurses may fill the gap left by these studies. Additionally, structural empowerment presumes an external locus of control and ignores feelings of competency

and self-efficacy. Examining psychological empowerment contributes to the holistic well being of nurses.

Psychological empowerment within nursing. To fully examine empowerment of nurses, psychological empowerment must be addressed. Conger and Kanungo (1988) asserted that empowerment was a motivational construct and a personal attribute of self-efficacy. This concept is congruent with Bandura's (1997) description of self-efficacy. Those nurses who lack self-efficacy may feel vulnerable (Ozer & Bandura, 1990). Thus, nurses who have a strong sense of self-efficacy will feel empowered. Staff nurses reported feelings of vulnerability and a lack of empowerment, including feeling undervalued, lack of control within the work environment, and being demeaned by interprofessional interactions (Moores, 1993). However, in a grounded theory study, Moores (1993) asserted that nurses (n=18), developed feelings of empowerment through facing adversity. The processes to empowerment included confidence, comfort, competence, credibility, and control. The researcher suggested that although nurses belong to an oppressed population, individual nurses developed feelings of empowerment. The well-designed study clearly identified the underlying methodology, method of analysis, and generation of a theory. However, participants were passive in creating knowledge. Moreover, this homogeneous sample may not be representative of ethnically diverse nurses. Albeit, feelings of self-efficacy are the basis of psychological empowerment, complex factors contribute to feelings of empowerment.

Kuokkanen and Lein-Kilpi (2001) explored the multiple factors that contribute to psychological empowerment. Empowerment from individual nurses' (n=30) point of view was explored in a qualitative study. The aim of the study was to gain deeper insight

of nurse empowerment. This aim was met through nurses' descriptions of an empowered nurse, how she performs her tasks, and what promotes and prevents empowerment. In individual interviews, participants were asked questions concerning belief systems and values, influence on own work, competence, meaning and importance of work, and self-determination. Five categories of an empowered nurse were identified. These categories included moral principles, personal integrity, expertise, future orientation, and sociability. The categories are congruent with empowerment as described by Spreitzer (1996), Bandura (1997), and Gibson (1991). A finding identified by the researchers is that within an organization, an empowered nurse could still flourish due to personality qualities found within the empowered nurse. The personality qualities were consistent with Bandura's (1997) description of persons with high self-efficacy, including flexibility, self-assurance, and strong social interaction traits. However, if the organization demonstrates harsh obstructions or barriers, the nurse would change jobs. This study was conducted in Finland and, therefore, may not be transferable to other cultures or countries. Replications of this study in diverse settings may improve transferability. Based on the findings of this study, the investigators continued their inquiry in nurse empowerment and developed a questionnaire that measured nurse empowerment.

Quantitative methods were developed to measure psychological empowerment. Kuokkanen, Leino-Kilpi, and Katajisto (2002) developed and tested a quantitative questionnaire, based on the findings from their qualitative study. The questionnaire evaluated how nurses assess their personal qualities and how they performed as empowered nurses. Registered nurses (n=416) were randomly selected from an employee registry in long-term care, public health, and critical care facilities in Finland. The

instrument measured moral principles, personal integrity, expertise, future orientation, and sociability. The Likert Scale questionnaire was validated by respondents of two pilot tests and deemed reliable by Cronbach's α coefficient of the sum variables 0.88-0.91. The participants who defined themselves as empowered were more likely to be future oriented and described activities in relation to the ideal model of nurse empowerment. Nurses who worked in long-term care had the highest sense of empowerment while nurses who worked on a temporary basis had the lowest sense of empowerment. The participants described the moral aspect of their work as coming closest to the ideal model. Those nurses who had been working the shortest period of time felt less empowered than those who had been working longer.

Limitations of the validation of the instrument was the lack of inclusion of education as a variable that may have influenced the analysis. Additionally, the researchers do not describe statistical power in the study nor do they identify assumptions of the multivariate analysis, thus calling into question the reliability of the findings. As the instrument uses a Likert Scale measurement, the dependent variable is continuous and cannot be dichotomized; thus, the more robust method of data analysis, a logistic regression cannot be used. However, the researchers state that differences between the groups were tested with an analysis of variance (ANOVA). ANOVA is a means of comparing the "ratio of systemic variance to unsystematic variance" in an experimental design (Field, 2011, p. 349). ANOVA uses the F ratio to evaluate the overall fit of the model. ANOVA must meet assumptions of parametric testing, including homogeneity of the slope. ANOVA appears robust if group sizes are equal. If group sizes are unequal, the accuracy of F is affected and increased the potential for a type I error. The

researchers did not describe the overall fit of the model; however, they did identify that the Tamhane multiple comparison test was used when the assumption of equal variances was not correct. Additionally, the *P* value less than .05 was considered statistically significant. As the participants were a homogeneous group of nurses from Finland, the findings may not be extrapolated to other cultures. The questionnaire was used in further studies to measure psychological empowerment of nurses.

Kuokkanen and Ktajisto (2003) continued to advance the social psychological approach to nurse empowerment. The authors contended that the exercise of power must be understood at the individual level and must be considered from the individual's point of view. Empowerment within this context is a process of personal growth. The purpose of this study was to investigate nurses' views to work related empowerment. Specifically, using a questionnaire, the nurses were asked to identify factors that are associated with promoting or impeding empowerment in relation to the ideal model of empowerment. Participants (n=600) were Registered Nurses randomly selected from long-term care, critical care, and public health. Factors that explained perceptions of work empowerment included job satisfaction, esteem, career consciousness, permanent work status, and commitment to the job. Impeding factors included authoritarian leadership and poor access to information. The investigators highlighted one finding that nurses who felt that their work was not rated highly would seek a new job or a new profession. The limitation of this study is the use of Likert scale results as the dependent continuous variable and homogeneity of the participants.

Factors that influence empowerment included job satisfaction. However, the analysis did not correlate intent to leave the job. Kuokkanen, Leino-Kilpi, and Katajitso

(2003) investigated the relationship of nurse empowerment, job related satisfaction, and organizational commitment. Finnish nurses (n=600) were randomly selected from long-term care, critical care, and public health facilities to participate in a questionnaire survey. Overall, the nurses were fairly satisfied with the profession with those who were dissatisfied, accounting for 8% to 15% from each workplace, while 18% to 22% were dissatisfied with their job. A large number of respondents had considered changing jobs (38-60%) while 27% to 38% had considered leaving the profession. Those participants who felt they were appreciated did not intend to leave their jobs (p< .001). Nurses who had higher perceived levels of empowerment demonstrated higher levels of commitment to the organization (p< .001). Older nurses, ages 51-60, had higher levels of empowerment and organizational commitment than younger nurses (p< .001). Additionally, further education and organizational activities correlated positively to empowerment. Community health nurses were the most likely to feel empowered and the least likely to change professions. The limitation of this study was congruent with the aforementioned studies taking place in one region of Finland. Psychological empowerment and structural empowerment contribute to the overarching theme of nurse empowerment. However, nurses are an oppressed group and a critical approach to conceptualizing empowerment contributes to the holistic concept of nurse empowerment.

Critical social theory empowerment within nursing. Critical social theory and empowerment of nurses is a nascent area of research and was explicated by Fulton (1997). Using Habermas' description of empowerment as a critical examination of power through a self-reflective process, the investigator sought to identify how nurses conceptualize empowerment, explicate nurses as an oppressed group, and recognize the

nurses' interest in their own liberation. Through two focus groups of eight participants,

the nurses demonstrated sensitivity to the empowerment of others; however, they did not

feel empowered. The groups identified that personal power is a process that is different

for each person, although personal attributes, such as assertiveness, knowledge, and

experience contribute to personal power. The power difference between the medical staff

and the nurses was identified as a barrier to empowerment. When asked to reflect on

how the nurses felt about themselves, themes of low confidence, low self-esteem

emerged. As nurses are an oppressed group, frameworks for investigating empowerment

must provide the means to address the unequal power structures inherent within the

healthcare system.

Meeting the Emancipatory Interests of Nurses

Literature related to nurses' empowerment demonstrates the passive participation

of the nurses and does not address the processes that they may use to improve the

circumstances of their work environment. To overcome the passivity of nurses within the

healthcare environment and to elicit experiences of empowerment, Cowling, Chinn, and

Hagedorn (2000, 2009) proposed an emancipatory method of inquiry that intertwines

with Freire's liberation theory (1970), Habermas' critical social theory (1973, 1979), and

feminist philosophy as described by Webb (1993) that will be explicated in Chapter

Three. Thus, nurses are active participants in creating new knowledge. Operationalized

in the *Emancipatory Study of Nursing Practice* (Cowling, Chinn, & Hagedorn, 2000,

2009), the inquiry sought to "elicit significant stories that reveal what it is like to practice

nursing today" and "to awaken an emancipatory response that can shape the future of

nursing." The purpose of the research was to "explore nurses' perceptions of the

circumstances of their work life through stories that reveal deep meanings concerning

nursing in today's context" (Cowling, Chinn, & Hagedorn, 2000, 2009, p. 1).

Additionally, the purpose was to "describe the process by which nurses conceive and

create change in these circumstances" (Cowling, Chinn, & Hagedorn, 2000, 2009, p.1).

Action occurred through active participation and problem-solving.

The study was emancipatory in nature. Designed to build on the idea of

emancipatory context, the assumption was that "participants seek to know that which is

not yet known to transform the conditions of their lives" (Cowling, Chinn, & Hagedorn,

2000, 2009, p. 1). Participation was conceptualized as a dialectic process of "reflection

and action that is embodied in dialogue, an essential element of which is critical

reflection" (Cowling, Chinn, & Hagedorn, 2000, 2009, p.4). The study was conducted on

the nursemanifest.com website. Visitors to the page were invited to participate in the

research. Participants were nurses (n=52) who anonymously sent a story that described,

"what it is like to practice nursing today" (Cowling, Chinn, & Hagedorn, 2000, 2009,

p.1). The stories were analyzed for common themes related to context of practice,

common story lines, and common tensions. Ultimately, the themes were developed into

metastories, fictionalized accounts, and artwork that demonstrated commonality of

experiences. The outcomes of the study were represented in a fictionalized story, a

fantasy tale, a 13-stanza poem, and photographic artwork that demonstrated the

constraints that nurses felt within the healthcare system and methods that they used to

overcome those constraints.

The Nurse Manifesto (Cowling, Chinn, & Hagedorn, 2000; 2009) study was

followed by a second emancipatory study of contemporary nursing practice (Jacob et al,

2005). The purpose of this study was to "explore nurses' perceptions of the circumstances of their work life in the context of today's reformed healthcare system and to describe the processes by which nurses conceive of and create change in these circumstances" (Jacobs et al, 2005, p. 8.). The philosophical tenets of this inquiry were reflective of the *Nurse Manifesto* study (Cowling, Chinn, Hagedorn, 2000, 2009). The elements of feminist influences within the method were explicated as a diminished power hierarchy between researcher and participants and a description of women's experiences with a structural analysis of women's lives (Jacobs et al, 2005, p. 8). An emancipatory methodology was chosen to "foster a context in which all participants sought to know that which is not yet known in order to transform the conditions of their lives" (Jacobs, et al, 2005, p.8). Through dialogue, new knowledge was illuminated, and emancipatory interests were met. The dialectic process provided the opportunity to uncover constraints on nursing practice.

The dialectic process was used to facilitate a critical reflection of circumstances of the participants (Jacobs et al., 2005). Praxis was described as reflection and action through a critical dialogue that explicated the circumstances of the nurses' work life. Themes that arose included feelings of loss of control, devaluation, and issues related to horizontal violence. However, the nurses' identified that increasing nurses' visibility in popular culture and expanding nurses' political activity may improve the circumstances of the nursing profession. Strategies for nurses nurturing nurses included methods of mentoring and increased presence in the structures of healthcare. Jacobs et al. (2005) identified that it was beyond the scope of the study to determine how many of the changes may be enacted.

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Jacobs et al. (2005) diverged from the *Nurse Manifesto* (Cowling, Chinn, Hagedorn, 2000, 2009) using group process as a method of eliciting nurses' narratives. Three groups of 8-15 nurses met weekly over six to ten weeks. All participants were female to eliminate gender differences. Discussions revolved around the circumstances that affect nursing practice. Data analysis began in groups through critical reflection. Empowerment, as a process, occurred through participants' increased awareness of their own histories and worth as persons who served to emancipate them from the organizational and professional limitations. For a final analysis, the researchers identified themes that arose from the participants' group analyses. The inquiries did not include the experiences of African American nurses. Love (2009) identified this gap and conducted an emancipatory inquiry with a focus on African American nursing students.

African American nurses were excluded from emancipatory research. Love (2009), a doctoral student of Jacobs and Fontana, conducted an emancipatory study with African American women at predominately White nursing schools, the purpose of which was to imagine an ideal school and to have the participants feel empowered to make changes. Using the Chinn method as described by Jacobs et al. (2005), nine participants met weekly for eight weeks to explore the experiences of being an African American woman in a predominately White school of nursing. The participants identified barriers to success and described their ideal school with potential processes that the participants could take to realize their ideal. Barriers to success included instances of racism and fears of retaliation. The students characterized an ideal school as one that promotes peace, justices, holism, and high standards. Methods to attain the ideal school included workshops on cultural compassion, education for teaching methods, and mentorship for

faculty. The outcome of the study was that the participants felt validated and empowered. The study was limited to a small group of nursing students in a large research institution in the northeast United States. Narratives may be different in other areas of the country. However, the participants identified barriers to success and new knowledge was illuminated.

Conclusion

The review of the literature demonstrated that increasing African American presence in nursing will improve overall health in the United States. African American nurses have experienced significant oppression through discriminatory practices in education, segregation in professional organizations, and a lack of professional opportunities. The literature that described African American nurses' experiences did not address empowerment nor were nurses' active participants in the research process. The body of literature on empowerment focuses on structural, psychological, and critical social theory empowerment and omits the experiences of African American nurses. Variables that contribute to empowerment of all nurses include continuing education, strong feelings of self-efficacy, and organizational structures that support nurses. Empowerment of nurses is linked to satisfaction and retention of nurses within the healthcare environment. The growing body of literature that addresses critical social empowerment and emancipatory literature does not explicate the processes of empowerment of African American Registered Nurses.

CHAPTER III

METHODS

This chapter provides an overview of the inquiry. The philosophical underpinnings and an explanation of the method are presented. Reflexivity in the emancipatory process is explicated and personal and research assumptions are identified. Procedures for identification and recruitment of participants are outlined. A data analysis method, congruent with the philosophy of the methodology, is identified and discussed. Protection of the participation is explicated.

African American nurses face challenges and barriers inherent in the American culture and the healthcare system. The purpose of this emancipatory inquiry was to explore African American nurses' professional experiences within the context of the healthcare environment. The phenomenon under study was empowerment as defined by Chinn and Kramer (2011). Empowerment, within the context of this inquiry, was defined as a process and entails a critical examination of unequal power structures that oppress a disenfranchised group and allow their voices to be heard (Chinn & Kramer, 2011). The Cowling, Chinn, and Hagedorn (2000, 2009) emancipatory research method provided a strategy for analysis of the nurses' experiences and an examination of power structures (Meleis, 2012). Emancipatory interests are met through an exploration of the hegemonic and potentially harmful practices enacted by governments and institutions (Jacobs et al.,

2005; Meleis, 2012). As nurses are an oppressed group, a critical analysis of hegemonic structures must occur.

Inquiry must reflect a critical and in-depth analysis of nurses' situations and focus on nurses' potential actions versus what others can do for nurses. Through this inquiry, African American nurses envisioned potential actions that may be taken to overcome oppressive mechanisms. Through engagement with participants and recognition of their own agency, this inquiry was designed to be empowering to all and emancipatory (Anderson, 2014). Thus, the method involved praxis or the critical reflection that allowed theory and action to intertwine (Dunphy & Longo, 2010). To fully understand the method, the philosophical underpinnings are described below.

Theoretical Tenets of the Inquiry

The research design of this inquiry was adapted from Jacobs et al (2005) and Cowling, Chinn, and Hagedorn's (2000, 2009) investigations. As described in these investigations, the theoretical tenets and philosophical underpinnings of the current inquiry include Habermas' critical social theory (1973,1979), Freire's *Pedagogy of the Oppressed*, and feminist theory as described by Webb (1993). The three philosophical underpinnings intertwined to meet the emancipatory interests of the inquiry.

Habermas' Critical Social Theory

Critical analysis of hegemonic structures is inherent in emancipatory methods and contributes to emancipatory knowledge. Habermas (1979) asserted that there are three distinct areas of knowledge and inquiry. These areas include technical, practical, and emancipatory interests. Technical knowledge is predictive, provides causal explanations, and arises from empirical positivist research methods. Practical knowledge

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encompasses interpretation and understanding of a phenomenon and is discovered

through hermeneutic interpretative research methods. Lastly, emancipatory knowledge is

based in criticism and liberation interests (Agger, 1991; Carnegie & Krieger, 2009).

Emancipatory knowledge is reflective and arises from critical theory, critical

research methods, and critical self-reflection (Dunphy & Longo, 2010). Critical

researchers seek to understand a phenomenon and alter oppressive circumstances leading

to emancipation, social justice, and equality (Carnegie & Krieger, 2009). Emancipatory

knowledge is located within historical, economic, racial, and social processes of injustice

and oppression. Emancipatory interests are met through an exploration of the hegemonic

and potentially harmful practices enacted by governments and institutions (Jacobs et al.,

2005; Meleis, 2012). Thus, the critical researcher investigates a phenomenon within the

context of history and seeks to illuminate injustices.

Illuminating oppressive structures and injustices occurs through dialogue.

Oppressive structures may be exposed through an examination of communication and an

illumination of symbolic meanings, thereby leading to emancipation (Dunphy & Longo,

2010; Meleis, 2012). A communicative inquiry provides the foundation necessary for

critique of the oppressive nature of society and culture (Fontana, 2004). Through the

process of dialogue, participant identify oppressive and hegemonic structures, which

oppress the individual or group.   However, oppressed individuals may be unaware of the

hegemonic processes that limit freedom. Thus, emancipatory knowledge also arises from

self-knowledge and self-reflection. Through participation in the emancipatory inquiry,

individuals become aware and can act to overcome oppressive structures.

Self-knowledge and self-reflection occur through the dialectic process. Insights gained through critical self-reflection are emancipatory in that one recognizes the reasons for one's own problems (Habermas, 1973, 1979). Consequently, an investigation of a person's life history and development of critical self-awareness are necessary for emancipation. Ultimately, emancipation is a process that is attained through illumination of hegemonic practices, critical reflection, and communicative competence (Habermas 1979). Freire's philosophy (1970) was intertwined with Habermas' critical social theory (1973; 1979) and feminist theory in the research method used for this study. Like Habermas, the focus of Freire's work was on oppression of populations.

Freire's Pedagogy of the Oppressed

Freire's methodology is based on his theory of oppression (1970) and a commitment to equality between researcher and participant. Freire asserted that subordinate groups are immersed in the experience of oppression. Oppressors or dominant groups set the standards for the culture or organization and define the roles of the subordinate group. The subordinate groups attempt to emulate the dominant groups (Roberts, 2000). Nurses, as an oppressed group, attempt to emulate the dominant group. Freire (1970) suggested that oppressive and unequal power structures are maintained through education and that hegemony is sustained through rewarding those who support the dominant paradigm. Ultimately, the subordinate group is marginalized and oppressed. Freire (1970) suggested that there must be liberation from marginalization, thus the overall goal of his methodology is emancipation and human liberation.

The goal of emancipatory methods is human liberation. Emancipation and liberation occur when hegemonic social structures are deconstructed through dialogue

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(Freire, 1970). The purpose of dialogue is to recognize and critique practices and structures that cultivate oppressive paradigms and sustain inequalities. The dialogue assumes care and respect between participants, and a questioning of what each person knows, thereby creating new knowledge and paradigms. Critical reflection leads to critical consciousness that is a deep understanding of the world. Critical reflection analyzes the effect of awareness and experience of social and political inequities (Freire, 1970, 2014). Thus, through emancipatory inquiry methods, participants identify inequities.

Political inequities and oppressive structures are paternalistic in nature. Freire (1970) identified paternalistic structures as the foundation of oppressive dogma. However, an inherent weakness of this ideology was a lack of recognition of women's experiences. Only male oppression and praxis were explored. To overcome this intrinsic weakness in the methodology, specifically as nursing is a female-dominated profession, feminist methodologies are intertwined to complement and complete the theoretical and methodological foundation of the proposed emancipatory method.

Webb and Feminist Theory

Feminist methodologies, as described by Webb (1993), embrace equality, explicate women's experiences, and provide a structure for analysis of women's lives. Proponents of feminist epistemology maintain that knowledge is situated within culture, time, place, and history (Chinn, 2001; Webb, 1993). Situated knowledge embraces the concept that the individuals' perspective promotes their understanding of an issue. Individuals who have experienced the phenomenon are the experts. Thus, feminist researchers assert that inquiry begins from women's lives (Hesse-Biber, 2012).

Furthermore, critical feminist theorists posit that a phenomenon must be explored and critiqued with the goal of empowering women (Webb, 1993). Through a feminist critical examination of paternalistic systems, knowledge is created, and women are empowered.

Empowerment occurs when feminist inquiry challenges viewpoints and assumptions that disregard women's equal status (Meleis, 2012). Feminist theory and methodology should be concerned with women's oppression and improving the state of women's lives (Webb, 1993). Methodology should challenge and critique the concepts of women's traditional place in the culture, and methods of inquiry should be non-hierarchical. Inquiry must occur within a setting that provides equality amongst all participants. Through dialogue and empowering language, hegemonic practices are illuminated and enlightenment and consciousness raising occurs (Meleis, 2012). Thus, feminist inquiry is praxis-oriented and should be committed to questioning the status quo and empowering women. Feminist theory, Habermas' theory, and Freire's theory are interwoven to create the foundations for this emancipatory inquiry. The research design encouraged active and equal involvement from all participants to develop new knowledge that may improve the conditions of people's lives.

Research Design

The research design was constructed to illuminate and explore hegemonic structures. An adaptation of the Cowling, Chinn, and Hagedorn (2000, 2009) method of emancipatory inquiry was appropriate to the purpose of this inquiry as it explored African American nurses' professional experiences within the context of the healthcare environment and explored meanings of empowerment. Emancipatory interests were met

through an exploration of the hegemonic structures experienced by the nurses. The inquiry promoted a critical reflection of the circumstances of the participants.

Critical reflection and meanings of empowerment were reflected in the research questions. The research questions were designed based on the purpose of the inquiry and founded on the work of Cowling, Chinn, and Hagedorn (2000; 2009). Thus, the specific research questions are as follows:

1. What is it like to be an African American nurse in a predominantly White profession?

2. What are African American nurses' subjective experiences of empowerment?

3. What are African American nurses' visions of an ideal work environment?

4. How do African American nurses conceive of creating change within the work environment?

The research questions were emancipatory in nature seeking to illuminate the circumstances of the nurses' lives, describe and define the concept of empowerment, and praxis through conceiving of change. In addition to identifying the research questions, assumptions of the research activities must be identified.

Research Assumptions

Assumptions of the inquiry are those factors believed to be true and plausible. The assumptions of the research activity were as follows: (a) the participants will actively engage in dialogue about their professional experiences; (b) the responses of the participants will accurately reflect the nurses' professional experiences; (c) there are barriers that impact the professional success of the nurses within the workplace and empowerment arises from an examination of these barriers; and (d) participants are active

in creating new knowledge. In addition to identifying the research assumptions,

reflexivity provided the means to ensure validity of the study.

Reflexivity

Reflexivity is a method of ensuring validity in qualitative research (Munhall,

2010). Reflexivity makes the researcher aware of potential bias, promotes self-

awareness, and awareness of how the researchers' presence affects the research process

and the participants (McCabe & Holmes, 2009). Reflexivity in emancipatory research is

essential, as the research process itself may prove to be a power imbalance between

researchers and participants. Reflexivity and decentering are required to continuously

avoid the researcher's personal biases and beliefs.

Reflexivity and Decentering

Reflexivity embraces the concept that a researcher's history influences the

narratives and interpretation of the experiences (Mccabe & Holmes, 2009). Munhall

(2010) suggested that everyone has a unique perspective and that the researcher must

identify their own perspective through unknowing. Unknowing is a condition of

openness (Munhall, 2010). Unknowingness can occur when one reflects on one's own

beliefs, preconceptions, intuitions, and biases. This reflective process is known as

decentering and is congruent with the philosophical underpinnings of the method.

Decentering. I am a Caucasian female nurse from an educationally and

socioeconomically advantaged background. Until the middle 1990s, although I lived and

worked in a southern city, I was unaware of the implications of bias, prejudice, and

racism. This unawareness changed abruptly when I left administration and accepted a

position in community health as a case manager in the inner-city projects. For the first

time, I saw how other people lived. I saw the harshness of the environment, the barrenness of the projects, and the paint peeling on the playgrounds. I cared for African American elders who had not attended school, either going to work to support their families at an early age or because of the school closings in protest of desegregation. I sat on front porches with African American women, discussing mammograms and other health screenings. However, I also became aware that even though I cared deeply for these families and women in this disadvantaged community, I was *other*.

The local PBS television station aired an interview of retired African American nurses who were also alumni of my university alumni organization. I recognized one of the women as the nurse who had oriented me when I was a new graduate. These nurses told stories of their experiences as nurses before and after desegregation. Their stories humbled me. I reflected on the days, sitting on the front porches and in living rooms and realized that nurses who were not "other" may affect even greater change in the health and well-being of the families and women for whom I cared. I began to investigate the experiences of African American nurses, some of which were discussed in the literature review. In preparation for this inquiry, I addressed my personal assumptions.

Personal assumptions. My assumption was that culturally-congruent nurses will improve the health of populations. I do not believe that a dominant group may speak for others. This belief was translated in the chosen research method. This emancipatory method provides a mechanism for African American nurses' voices and ideas to be heard. Congruent with Freire's philosophy (1970), I can be a tool for others to share their experiences so that their ideas can be disseminated. My assumptions, related to African American nurses, include the significant role of spirituality in their personal and

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professional lives and that the nurses have experienced issues of racism and significant barriers to success within the healthcare setting and the profession of nursing.

Population and Sampling

To fully answer the research questions, purposive sampling was chosen. Purposive sampling is a method of sampling whereby participants are chosen, based on two criteria (Munhall, 2010). The criteria include the fit between the participants' experiences and the research question and characteristics of a good informant. The participants must be experts in the phenomenon and be willing to talk about their experiences. Additionally, the sample must be developed based on certain criteria including similar work experiences (Flick, 2014). The participants must have similar experiences with the phenomenon to fully answer the research questions.

To ensure the participants had similar experiences with the phenomenon specific inclusion criteria were identified. For this study, inclusion criteria for the purposive sample included (a) African American licensed registered nurses; (b) females; (c) live and work in a Mid-Atlantic region; (d) five or more years of work experience within a healthcare setting as registered nurses; (e) BSN as the highest degree held at the time of the interview; and (f) employed within the healthcare system. Female nurses were recruited to maintain the feminist perspective of the inquiry and illumination of the experience of women's lives (Flick, 2014; Jacobs et al., 2005; Munhall, 2010). Nurses with five years or more of work experience were chosen as nurses with extensive experience may be more information-rich than less experienced nurses (Flick, 2014). Delimitations for study participants were made to maintain similar experiences.

Exclusion criteria included nurse managers and advanced practice nurses to maintain a focus of inquiry to analyze the research questions.

Recruitment of Participants

Upon approval from institutional review board at the University of North Dakota, potential participants were recruited, using the snowball technique. The snowball technique relied on a point of contact, referring potential participants to the researcher (Browne, 2005; Munhall 2010). Points of contact were found in the researcher's professional network and through other participants. When a potential participant was identified, an invitation to participate in the inquiry was sent via email, explaining the purpose of the inquiry and parameters for inclusion in the study (Appendix A).

The participants contacted the researcher either by telephone or email. Upon being contacted by a participant, an initial telephone contact was made to further discuss the study and answer questions. Additionally, an initial screening was completed during the telephone call that ensured that the potential participant met the inclusion criteria. The researcher also asked the potential participant if she knew of other nurses who were interested in participating in the inquiry. Four of the participants recruited other participants.

A limitation is the snowball technique is that it may exclude certain individuals and groups, thereby potentially creating a power imbalance (Browne, 2005). By employing the snowball technique, the sample may have excluded potential participants outside of the researcher's professional and social network. Although the snowball technique may offer access to hidden populations, the technique may also produce secondary hidden populations.

Data Collection

Individual interviews were conducted in comfortable and convenient locations chosen by the participants. A total of eight interviews were held. Six face-to-face interviews occurred in libraries, private offices, and in participants' homes. Two interviews occurred by telephone. The duration of the interviews was one to three hours.

During the interview, demographic data was only collected to substantiate inclusion in the study (Appendix B). The information included work status, years working as a registered nurse, current clinical experience, highest education level, and self-identification as an African American Registered Nurse. The data was aggregated to describe the participants. A participant number was maintained separately from the data in a locked drawer.

A semi-structured recorded interview process was used to explore the experiences of the participants, answer the research questions, and meet the emancipatory interests of the inquiry. The six interviews conducted in person were transcribed verbatim. Notes were typed verbatim during the two telephone interviews by the researcher. These telephone interviews were not recorded. The researcher listened for themes during the interview process. Interview questions were constructed to answer the research questions and were based on the previously identified emancipatory studies (Appendix C). Participants shared subjective experiences during the interview process.

Communicating the Experience

Subjective experiences were elicited through an open-ended, semi-structured interview process. Semi structured interviews enabled the participants and the researcher the opportunity to "explore the unique experiences that they have encountered

in their life worlds" (Rose & Glass, 2008, p. 14). The participants were encouraged to expand on answers using stories to illustrate and expand on their thoughts.

The researcher was aware that narratives and storytelling are ways that people make sense of their world and that the experiences that are recounted are historically located and of the moment (Banks, 2014). Both the participants' and the researcher's histories influence the narratives occurring in interviews and data analysis (Doane, 2014; Reimer-Kirkham & Anderson, 2010). Thus, the researcher continuously reflected on preconceived ideas and beliefs so that her assumptions were accounted for within the narrative. Field notes were taken during the interview process that included the researcher's perceptions and potential assumptions.

Throughout the inquiry, to enhance reflexivity, the researcher used a journal and answered the following questions, based on Evans-Agnew, Sanon, and Boutain's (2014, p. 142) recommendations. These questions are as follows: (a) how well am I balancing the need for critical distance and engagement? (b) how could my privilege be affecting my perspective? (c) how can I improve on protecting participants? and (d) am I observing what I set out to observe? The reflexive questions were used during data analysis.

Data Analysis

A feminist method of data analysis was chosen to align with the philosophical underpinnings of the method as no specific method of data analysis was explicated by Cowling, Chinn, and Hagedorn (2000, 2009). Within the constructs of Webb's (1993) assertion that feminist research must remove the power imbalance between the researcher and the participants and describe the experiences of women in their own expressions, the

proposed inquiry will focus on women's experiences and utilize a feminist method of data analysis. The method of data analysis outlined in the *Listening Guide* (Gilligan, Spencer, Weinberg, & Bertsch, 2003) was used to explicate the experiences of African American nurses. The method is congruent with the philosophical underpinnings of the inquiry as the method assumes that knowledge arises from women's lives and understanding arises from an exploration of their place in a social structure and individual agency (Edwards & Weller, 2012; Keigelmann, 2009; Mathner & Docet, 1997; Rose & Glass, 2008; 2010). The multiple steps of data analysis illuminated new knowledge that arose from the participants' lives.

Step one began a review of the transcription while listening to the recordings to ensure accuracy. During this step, the researcher listened for plot that included themes, contexts, and social circumstances (Edwards & Weller, 2012). Emerging themes were explicated and interactions between the researcher and the participant were reflected on in the analysis notes.

The second step identified how women speak about themselves and their place in the narrative (Gilligan, Spencer, Weinberg, & Bertsch, 2003). During the review of the narratives, the researcher highlighted any *I* statement. All *I* statements were placed in a separate document.

The third step was contrapuntal or listening for the different voices within the narrative (Gilligan, Spencer, Weinberg, & Bertsch, 2003). The researcher classified the various voices, identifying those that addressed the research questions and an identification of characteristic features, such as passive or active voice, use of first or third person, and use of images or metaphors. The researcher was attentive to both the

content of the participants' narratives and nonverbal methods of communication, including silences and patterns of speech, such as halting speech. The researcher noted that similar themes emerged after the third interview, saturation was achieved after six interviews. Two additional interviews were conducted to support the themes. Upon completion of the analysis, the researcher returned to the literature. Previous literature was used to compare and contrast study findings and substantiate the themes. Journaling occurred throughout the data analysis to record and identify the researcher's reflective thoughts and feelings (Rose & Glass, 2010) and ensure that the researcher's voice was accounted for in the analysis. Accounting for the researcher's voice within the narratives, contributed to the rigor of the inquiry.

Rigor

Although each person has her own perceptions that are built on culture, experiences, and history, trust in the research findings may be addressed, using Lincoln and Guba's model of trustworthiness (Thomas & Magelvy, 2011). Lincoln and Guba (1985) proposed four components of trustworthiness that included credibility, transferability, dependability, and confirmability. These components are described here with the strategies used in the study to maintain rigor. Qualitative research is considered credible when it presents an accurate reflection of the human experience and people will recognize that experience (Thomas & Magelvy, 2011). To assure credibility, the individual transcripts and *I statements* were evaluated for similarities across all the participants. Reflexive strategies were practiced throughout the inquiry.

Transferability

Lincoln and Guba (1985) asserted that the ability to transfer research findings and methods from one group to another determines the applicability the findings have on other groups. In this study, a description of the participants was provided, including demographics and geographic boundaries. The findings of this study, however, were not intended to be generalizable to other populations. The intention was to describe a specific group of African American nurses' experiences who shared their stories in response to the research questions. In addition to transferability, dependability is a component of trustworthiness.

Dependability

Dependability arises from a clear decision trail used by the researcher. The decision trail included a description of the purpose of the study, a discussion of why the participants were selected for the study, a description of data collection, a discussion of data analysis, and a discussion of the presentation of the research findings (Lincoln and Guba, 1985). Data is presented in Chapter 4. Extensive quotes were used to improve dependability. As the researcher was a novice, experienced researchers guided the novice throughout all stages of the inquiry. Additionally, to increase transparency and assure audibility, an audit trail was maintained that included field notes, personal notes, transcribed interviews, and the researcher's reflective journal (Munhall, 2010). In addition to dependability, confirmability contributes to trustworthiness.

Confirmability

Confirmability occurs through reflexivity (Lincoln and Guba, 1985). Reflexivity included field notes and journaling. Specifically, the researcher reviewed the following

questions: (a) How well am I balancing the need for critical distance and engagement? (b) How could my privilege be affecting my perspective? (c) How can I improve on protecting participants? (d) Am I observing what I set out to observe? (Thomas & Magelvy, 2011). In addition to ensuring trustworthiness, the researcher must account for ethical considerations.

Ethical Considerations

Although the study participants were not a protected special population for research, the participants were members of a vulnerable population. The protection of the participants was the highest priority of the researcher. Institutional Review Board (IRB) approval was obtained from the University of North Dakota. A second IRB approval was obtained after the closure of the original approval due to the researcher's leave of absence. The researcher successfully completed *The Collaborative Institutional Training Initiative for Human Research Curriculum* and the National Institutes of Health Office of Extramural Research *Protecting Human Research Participants* course. Upon review of ethical considerations and IRB guidelines, the researcher determined that the participants were at minimal risk.

The inquiry presented no major risks. However, the minimal risk of interviews was the potential trauma for remembering disturbing events. The researcher has a background in mental health nursing and was aware to observe for signs of potential trauma. These signs include crying, tensing of the muscles, raised voices, or withdrawal. To emotionally support the participants, breaks were offered, and debriefing followed the discussion. Debriefing involved an informal dialogue about the experience of the discussion upon conclusion of the interview (Stevens, Lord, Proctor, Nagy, & ORiordan,

2010). The risks to the participants was included in the Informed Consent.

Since this study had no major risks and adults were interviewed, an expedited IRB review was obtained. The Invitation Letter (Appendix A) and the Informed Consent Form (Appendix D) were written, according to the guidelines of the Office of Regulatory Compliance. The participants and the researcher signed two copies of the Informed Consent Form. The Invitation Letter and one copy of the Informed Consent Form was given to the participant. The other copy of the Informed Consent Form was kept in a separate locked file. The consent forms were kept separately from all other data.

The participants were not coerced in any way to participate in the study. A twenty-dollar gift card was offered to offset any costs associated with participation. Participants self-selected to contact the researcher, based on the invitation letter and referrals from friends and colleagues. The participant contacted the researcher to discuss her potential interest. The participant was also able to contact the researcher for more information about the study without revealing her identity. Only when the participant decided to participate did the researcher seek identifying demographic information. The participant was free to withdraw from the study at any time. No identifying information was maintained in the demographic data; thus, confidentiality was maintained.

Anonymity was not possible in this study, as the researcher came to know the participants during the interview. Thus, the researcher assured confidentiality for the participants. All audio recordings, transcriptions, field notes, and research journals were kept in a locked drawer in a locked office. Only the researcher and the dissertation committee had access to the recordings and transcripts. In addition, computer files were password protected. Access to computer files and other sensitive information was limited

to the researcher and the research mentor. The audio recordings and any identifying written data will be destroyed after all publications are completed upon completion of the dissertation.

Conclusion

This chapter provided an overview of the inquiry. The philosophical underpinnings and an explanation of the method were presented. Reflexivity in the emancipatory process was explicated, and personal assumptions were identified. Inclusion and exclusion criteria were detailed, and recruitment of participants was outlined. A feminist data analysis method congruent with the philosophy of the methodology, was identified and discussed. Protection of the participation was presented. Chapter IV will present the findings of the study.

CHAPTER IV

RESULTS

This chapter presents the data analysis from interviews with African American nurses. Two overarching themes were identified including (a) oppression is multifaceted; and (b) empowerment is being a voice for self and others. Subthemes were explicated that supported the overarching themes of the data analysis.

Interviews were conducted with African American nurses both in person and via telephone. Participants held similar degrees and worked in similar healthcare environments with comparable responsibilities. The participants all chose pseudonyms: Carole, Lynne, Jackie, Helen, Margaret, Karen, Jill, and Marie. Pseudonyms were omitted in specific parts of the analysis if a statement could potentially identify a participant. A feminist method of data analysis utilized three steps of analysis. Step one involved a review of the interviews and identified emerging themes. During the second step, the researcher reviewed the narratives and highlighted any *I* statement. All *I* statements were placed in a separate document. This visualization provided the researcher with the opportunity to begin refining themes and subthemes within the context of the women's lives in relation to the work environment. Contrapuntal voices were clearly identified during the third stage of data analysis.

This emancipatory inquiry sought to answer the following research questions:

1. What is it like to be an African American nurse in a predominantly White profession?

2. What are African American nurses' subjective experiences of empowerment?

3. What are African American nurses' visions of an ideal work environment?

4. How do African American nurses conceive of creating change within the work environment?

In keeping with this method, the areas of emphasis included examining hegemonies, identifying structural inequities, and framing and anticipating transformative action (Kagan, Smith, & Chinn, 2014). Research questions numbered three and four related to praxis and participant recommendations for future directions in research, leadership, and education; therefore, those topics will be addressed in Chapter Five. Thus, two overarching themes were identified through an examination of hegemonies: identifying structural inequities and defining the concept of empowerment. These themes included (a) oppression is multifaceted and (b) being a voice for self and others (Table 1).

Table 1. Themes.

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Overarching Theme	Categories within Each Theme
Oppression is Multifaceted	Experiencing Oppression • Personal Experiences of Oppression • Hierarchal Structural/Systems and Oppression
Empowerment is Being a Voice for Self and Others	Experiencing Empowerment • Autonomy, Expert Knowledge, and Education • Having a Voice • Working to Your Full Potential • Empowering Others is Empowering to Self

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Oppression Is Multifaceted

The participants identified multiple oppressive structures with their narratives. Kagen, Smith, and Chinn (2014) identified unpacking hegemonies as a critical element in emancipatory research methods. The participants described multiple hegemonies in their work environment. The theme that oppression is multifaceted arose from their stories. Subthemes that supported the overarching theme included experiences of racism, the effects of experiencing racism, and feelings of isolation. Additionally, the participants described age and sex as oppressive mechanisms. Finally, the participants identified that systems of oppression included the hierarchal structure of administration and within the interdisciplinary team.

Personal Experiences of Oppression

"When you are an African American you get used to that kind of behavior." (Karen)

The participants described multiple experiences of perceived racism within the work environment. These experiences included the perception of having to work harder than Caucasian nurses, receiving biased evaluations, lack of advancement, and unfair work assignments. Additionally, participants described experiences of being viewed by patients as a nurse aide or Licensed Practical Nurse (LPN). Finally, the participants described incidents where patients refused care because they were African American.

African American nurses must work harder. When describing what it was like to be an African American nurse in a predominately Caucasian profession, the participants described perceptions that they must work harder than their Caucasian counterparts. Carole affirmed, "I have to be better. I have to be bolder. I have to be more outspoken, and I have to be adamant about what I do. I have to push harder. It's all

about proving that you are worthy." The assertion was supported by Lynne: "I have to work harder. I have to do double as a Black person than you have to do as a Caucasian. It's almost like you have to be a super person." Helen shared, "You have to do double as a black person than as a white person and you don't advance." Marie described the following, "It comes from a mindset of African Americans won't do as well as Caucasians. When you do well in the profession, I think that other people think it's an astounding thing." Jackie asserted, "Sometimes people doubt your abilities as a minority then that is all the more reason to study more and know your job." In addition to the perception that African American nurses must work harder than their Caucasian counterparts, the participants also perceived that performance evaluations and lack of professional advancement were influenced by racial bias. Carole stated:

> I perceive that I am slighted on my evaluations because I am Black. You hear someone else did a great job and you think "I did that better" It is always in the back of your head. It's like the elephant in the room or you try not to think like that, but it is always the question why did that happen because you can't look at someone's face and say 'was it because of that?

> The participants referred to the loss or lack of responsibilities because of racial bias. Helen asserted, "I was a preceptor. Now I'm not. It's like a microcosm of everyday being Black."

Although the participants described their own instances of lack of advancement, they also focused on other African American nursing staff in the work environment. Margaret reported that a master's prepared nurse had not received a promotion to nurse manager "because she was Black. They obviously didn't say but we knew." Carole

reported that a senior nurse on her unit had not been promoted because of racial bias: "You have to work harder to get the position that other people just walk into."

Helen substantiated the assertion that African American nurses are not promoted due to racial bias. She shared the following anecdote:

We had a nurse manager there first. She was Black. They (administration) gave her a hard time. It's things like that; it seems they are kind of doing things under cover, but people can still see what's going on. She didn't keep the position because she was Black. That bothered me.

Jackie described a housekeeper who attended a nurse aide program.

She was an older black woman, and she wanted to become a CNA and then a nurse. Do you know they would not hire her as a CNA? They paid for her to go to school because they had to but they would not hire her as a CNA. She couldn't get a job. She is trying to do better and I guess she just got frustrated. We need them. It's a very valuable job as a housekeeper. It's just that the thought of her trying to advance herself and then they would hire her…it's horrible. I would have hired her. Who knows how many other Black women that may have happened to.

In addition to witnessing incidents of bias against staff, Marie identified Caucasian nurses' biases against African American patients.

Where I work is in an inner-city hospital in a predominantly Black neighborhood. The staff is predominantly White. Sometimes it looks like that aren't enough African American nurses for the population. You will only see Caucasian nurses. It's sometimes disheartening. They look down on the patients because they are

poor and black. The nurses can't relate to the patient in certain ways. It comes

along to cultural sensitivityand desire to learn. They don't seem to want to learn.

Nor it doesn't seem that they understood that you work in a predominately black

and poor neighborhood. One day I walked into a patient's room. She said "I am

so glad you are here." I knew what she meant. It was disheartening.

The participants shared stories of personal experiences of racial bias within the

workplace. Additionally, they discussed witnessing racism and bias against African

American coworkers and patients. The participant also shared stories of unfair work

assignments and disciplinary actions.

Unfair work assignments and disciplinary actions. In addition to the

perceptions of having to work harder than Caucasian nurses and racial bias in evaluation

and advancement, the participants asserted that they received unfair work assignments

and biased disciplinary actions. The participants shared accounts of unfair assignments

including reassignments. Jackie described an episode of being assigned to a unit to

provide staff development:

I was just doing my job, doing a good job. I am Black, but I don't let that play

into my life. There was another nurse. A white nurse and she said "We want

Jackie to go. I don't care because I am a float nurse (a nurse who is not assigned

a permanent unit) but I had been assigned to do staff development on that unit.

They told me to leave; the White nurse told me to leave and I left.

Margaret discussed unfair patient care assignments, "They give me harder

assignments." Helen stated, "I am shunned from doing certain things because I am

Black."

In addition to unfair work assignments, a participant discussed the disciplinary process.

> I have to be at work for 12-14 hours, so I needed to do some banking during the
> day. I wasn't neglecting my patient, but I was called into the office, sat down in
> the office and asked, "why were you on the internet?" "Well because I had to
> take care of some business. I wasn't neglecting my patient and I don't have an
> issue with you trying to reprimand me or trying to correct me, but it doesn't make
> sense what you are saying to me right now. I know of people that were white and
> that were dressing up in supplies and were placing them on social media at night
> and there was nothing said about that. So, you did not tell them to go into the
> office on their break and not be on the internet. And you have people having sex
> on the unit and nothing was really said about it. But then you are going to
> discipline me when I was checking my bank account?" So, what does that mean.
> Is that because I am Black? The difference was they were on social media and
> they were White, and I was doing this.

Karen described the manager and nurse relationship as a parental relationship when discussing disciplinary actions:

> Regardless of the age when it is comes to race it's like a parental relationship.
> The White person, supervisor or manager is paternal or maternal and the Black
> person being the child. When the supervisor is black it is more peer to peer.

The participants described instances of unfair assignments and disciplinary actions. A hierarchy based on ethnicity was discussed. These narratives were followed by descriptions of instances where the participants were stereotyped as nurse aides or LPNs.

Being viewed as a nurse aid. The participants shared multiple experiences of being perceived as an aide or an LPN by families, patients, and physicians. Carole who attended a prestigious baccalaureate nursing program stated that she was frequently asked if she was a medical assistant or an LPN. "I would state no, I'm an RN." She stated that patients, families, and visitors frequently asked if she had attended a local associate degree program. She stated that they appeared "surprised" when she told them the school she had attended. Lynne stated that the patients "don't see you as a nurse. They see you as an aide." Marie confirmed this stereotype:

> My ID is faded. You can't see the RN on my badge. Patients don't perceive me as a nurse. They will say "Oh you are a nurse?" Even when I am doing nursing duties. Giving medications. Providing patient teaching. I'm not seen as a nurse. The patients will ask "What kind of a nurse." I make sure to say I'm a registered nurse. Honestly, comes from African American patients also. I take that as sad because "you can't see us in that light? Making those kinds of achievements. I say: no we do this too.

In addition to patients and families, the participants described experiences with physicians who perceived them as nurse aides. Karen shared that she had reported a change in a patient's status to a physician and was ignored. The physician ultimately checked on the patient. The participant returned to work the next day and the physician approached her and stated, "I am so sorry. When you came to me, I thought you were an aide and I did not realize that you were a nurse." Jackie stated, "The doctors doubt your ability because you don't look like their daughter or their sister. They talk rough to you."

In addition to experiencing stereotyping, participants also shared stories of patients who demonstrated overt racism.

Patients who demonstrate racism. Participants shared stories of patients who refused care due to racism. A participant who was a former home health nurse, shared a story:

> I went to admit a patient. I thought we connected. The next day I was in the office and said I was going to call the patient to set up an appointment. An occupational therapist overheard and told me "um she didn't want you." She said to me: "she wanted someone of her own color." The patient didn't voice it to me. I called the patient and I told the patient that somebody else was coming.

Lynne reported multiple instances of patients and families refusing care from her because she was an African American nurse. "It's just patients have more power. Patients and their families are not comfortable with me." In each case, the participants reported that the administration capitulated to the patients demands, and Caucasian nurses were assigned to provide care. Carole stated that "I mean you want to make the client happy, but you also have to kind of educate them in a way to not make your staff feel uncomfortable." The participants stated that administration did not support the nurses. Carole specifically stated that the issues were "not looked into further by administration." Lynne reported, "The administration looks the other way." "I guess they think it is like a patient who does not want a male nurse." Margaret shared, "I was upset because administration should have done a little bit more and they don't. They're more worried about their patient satisfaction scores." The participants shared multiple stories of

racism. However, the researcher noted that the participants also described their responses to racism.

Response to racism. When listening for contrapuntal voices, the researcher noted that immediately after each personal story of experiencing bias and racism, participants shared methods of coping and the effects of experiencing racism.   In response to experiencing overt racism by patients, Carole stated, "I am at the point if you do not want me to take care of you, I feel that my license would be on the line if I did take care of you then there would be a lot of nitpicking." Coping with racism was also described by Jill.

> After Jill shared the story of a patient refusing care because of racial bias, she stated: That lady missed out I'm compassionate. She missed out on my care. We just have some people that are just set in their ways and they are not going to change. I'm not going to let that one incident ruin my love and compassion for nursing.

After sharing the anecdote of being told to leave the unit, Jackie made the following statement:

> I try to block it out. If someone is really mean I think it can't be because of me. I think they probably do treat us differently, but I block it out because I think only good stuff is supposed to happen to me. That's how I deal with it.   I try to not let it get in the way of being able to safely and effectively care for my patients.

> After sharing an incident of racism, Margaret acknowledged, "I've put up a shell." Lynne stated immediately after discussing a personal experience with racism,

"That's alright. When you are an African American you get used to that kind of behavior. You learn how to not internalize it and you just do what you have to do."

After describing her lack of advancement into administration, Helen avowed, I was here for the patient, so it didn't really bother me." Marie provided contradictory statements after a description of bias occurring in the health care environment: "It was disheartening. It didn't bother me. Nobody has ever given me a problem with it." In addition to emotional reactions to experiencing racism, one participant described physical symptoms of the strain.

One participant shared that she had experienced physical manifestations from the stress of work and experiencing racism: "I try not to let it affect me. Although, I ended up with back pain and TMJ (temporomandibular disorder). I couldn't unlock my jaw." In addition to sharing stories of experiences of racism and personal responses to racism, the participants discussed feelings of isolation.

Feelings of isolation. Feelings of isolation were evident in many of the interviews. The participants shared feelings of isolation throughout their professional lives. The participants shared stories of isolation in nursing school. Jackie described the differences in the LPN program.

> The LPN students were all Black. We laughed. We were loud. But I was the only Black student in the RN program. I felt alone. You wonder why there aren't more Black nurses. It's hard. I think sometimes they may be intimidated in school and weeded out easy. I think that there may be extenuating family circumstances that cause them to work and they are not able to have a chance to educate themselves.

Lynne described her experiences attending an LPN to RN bridge program. She stated:

We were a cohort of LPNs returning to our RN. We were all Black. There were

only White nurses on the units and they would look at us strangely and say you all

are having a good time. It was like we weren't serious about nursing." Another

participant described her experiences in an online program.

Marie shared:

When I was doing this online RN-BSN program, I've noticed that almost every

class was predominately white. I've only seen one African American. I was like

"Wow. There was another one to choose this school." To see that, I realized that

it was a predominantly white field. I was one of the few.

In addition to the nursing school, the participants discussed feelings of isolation in

the work environment. Marie stated:

There are units that are all Caucasian on days and on nights all African

Americans. In the ICU. I noticed it when I was back in nursing school. I was

working as a nurse extern. I noticed all of the nurses on nights were African

American. I thought to myself: "Do they think that African Americans can't

work on days? Is it because they are not seen as professional?" I never asked.

But it was a thought process. Why is that way? I chose to only work on the night

shift because at times I felt uncomfortable because I felt I didn't fit in on days. I

didn't belong. I was asked why I chose nights. I told them because all of the

Black nurses work at night. I told that to another African American nurse she said

that's right. That's where we are.

Carole acknowledged that when she began work in the Intensive Care Unit (ICU), she realized that she was the only Black nurse. She repeated frequently that she didn't understand why Black nurses in the ICU were rare:

> I think we have come to a point that there's not many of us, we kind of just stuck to ourselves. Black nurses in ICU are very rare. It's crazy to me why we are not in critical care. I don't understand why we are not in critical care. I don't understand why. I cannot. I am trying to figure out why we strayed from critical care.

Lynne pondered, "You wonder why aren't there more black nurses. Why is there a lack of black women who want to become nurses?" Karen also discussed the lack of African American nurses in the ICU. She stated, "I can be on a med-surg unit and you see a few Black nurses. I am the only one in ICU. It's lonely." Marie discussed working on a unit as an RN and stated, "I looked around and wondered why am I the only one?" Carole addressed the lack of African American nurses in the Post Anesthesia Care Unit (PACU). She stated that when she started in PACU, she asked herself "Why am I the only Black nurse here." The participants shared feelings of isolation. Additionally, the participants discussed incidents of nurses oppressing other nurses.

Nurses Oppressing Other Nurses

The participants described incidences of incivility and oppression from other nurses. Carole described the following:

> So, you have those nurses who are always trying to find something to knit pick about to make you feel that you are just a horrible nurse, and come to find out, she was not comfortable with her own bedside skills. So, in order for her to feel good

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about herself when she came to the ICU, she had to find something wrong with what you did. So, nit-picking is a big thing. Throwing each other under the bus. Margaret described experiences with new graduates and orientees, "They test them. They don't help them. It's the old saying. Nurses eat their young." Lynne described the lack of orientation of new graduates as an oppressive mechanism. "We just throw them out there and expect them to take care of all the patients, "They are not prepared to do that from nursing school. They just quit." Carole identified the lack of orientation and testing of new employees on units: "You know nurses eat nurses. The staff will test new employees. Give them hard assignments. Then they leave." Finally, Helen shared, "nurses talk about each other." She stated, "I have heard rumors about people. They're not true but the nurses keep it going. Then the person is isolated." In addition to nurses oppressing nurses, the participants discussed age as an oppressive factor within the work environment.

Age as an Oppressive Mechanism

The participants viewed age as a mechanism for oppression. Participants who were more experienced asserted that as nurses age, there is oppression. Helen, with 35 years of nursing experience stated, "Now that I am getting older I feel the nurses don't respect me. I feel that they think I am slow and that my knowledge skill isn't where it should be." Helen shared the following story:

> The only thing like my age. I feel like I am being shunned because of my age and
> because I am not as quick. A new graduate was always running and did my work.
> So I needed to take him aside and say 'Hold it, what's the problem. Do you think
> I am too old or do you think I just don't know what's going on. I know how to

take care of my patient. Don't be so quick to do my job. Just let me do my job I

still can function. I still can perform. That part hurt.

Margaret with 30 years of nursing experience stated, "They don't think I know anything

because I'm older."

Conversely participants who were less experienced identified younger age as a

mechanism of oppression. Karen with five years of nursing experience stated, "I look

young. The patients may not trust me because I am younger." "Sometimes I think they

see me as a daughter." Carole reinforced this assertion, saying, "I think the patients and

doctors don't listen to me because I am young." In addition to age as an oppressive

mechanism, the participants also identified being oppressed as a woman.

Being Female as an Oppressive Mechanism

The participants identified being a female as an oppressive mechanism within

their clinical practice. Jackie stated, "When the doctor wouldn't listen to me, I think it

was sexist. The Black male nurse would call the Doctor and he wouldn't yell at them. I

think it was because I was a female in that case." Carole stated, "You always wonder if it

is because I am a woman, I don't get respect." Margaret stated, "They talk down to

women nurses. They don't do that to the male nurses." Jill shared the following:

When I called a Doctor to ask if I could use a central line, he was rude and said

"look at your policy." A male nurse called and the same physician responded

"sure." If you're a lady nurse, they will talk to the director or CEO about our

conduct. The male nurses get away with all types of things. I think it's a weapon.

It's how they talk to women. Even female doctors tend to respect male nurses

more. One time a doctor kept talking to a male nurse like he was in charge. I was

in charge. During a procedure, the male nurse was at lunch. Upon return the

doctor came to talk to the male nurse. He wasn't even there!" Sometimes it's

more sexism than anything else.

The participants identified that sexism was a form of oppression within the work

environment. Additionally, the hierarchal structures were repressive.

Hierarchal Structures

"My voice is not heard." (Jill)

Participants identified multiple structural inequities that created barriers to

empowerment of African American nurses. These structural inequities were evidenced in

the hierarchal structures of administration and within the interdisciplinary team. The

participants frequently described their experiences as not having their voices heard.

Hierarchy within the interdisciplinary team. Participants shared experiences

that demonstrated the hierarchal nature of the interdisciplinary team. Jill discussed the

lack of communication within the interdisciplinary team as "oppressive." She continued,

"we all work in silos and nobody works together." The participants also discussed the

role of physicians within hierarchal structure of the interdisciplinary team. Jackie related

that a physician was responsible for her current role in staff development. She stated, "he

had the power. He helped me get where I am. He had all the power." Carole described

the influence of a physician in staffing practices of her unit. The unit had recently

eliminated a secretarial position, and the physician asked the nurses why no one answered

the phone. The nurses explained that the lack of secretarial support. Carole shared, "The

doctor went to them (administration) and said there is no secretary and the phone rings

and rings. No one answers me. After he went to administration, we got our secretary back."

In addition to the beneficence of a physician, the participants also related experiences of being ignored and not being respected. Jill stated:

In the hospital it is the doctors…they're not the ones at the bedside they aren't getting their true history. I wish the doctors would listen to us more and respect us more. They don't know your ability as a nurse. It is lacking in the hospital. I think that it is the doctors that create the lack of autonomy. The doctors are given a lot of power.

Jill reported:

My voice is not heard at all by doctors. Whatever I said, they didn't care. That's what   they were going to do, and you didn't know what you were talking about. I can do more than what the orders said. They could yell at you, call you out get up in your face, and administration would say "oh, that's just the Doctor.

Margaret stated, "I worked on a cardiac unit and the doctors just didn't want to hear anything that I said." Karen reported that physicians would ignore her. She stated, "I would go to the doctor and say Mrs. Jones is not doing well, and this is why. He ignores you." Finally, Helen shared her frustration with not being heard:

The doctors need to realize that nurses have qualifications and education. I work with medical students and being students, you try to tell them a certain way to do something, they don't want to hear. And then when something comes up they thank you for helping. Just because they are a doctor doesn't mean they know everything. Nurses have experience, too. That part frustrates me. The other part

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is when you talk to them they just want you to do what they say. Sometimes they say something, and I don't agree with them. I just go and do what I need to do. We're here for the patients first and not for the doctors to shine. They don't understand patient care. The doctor wanted a standing weight. The patient couldn't stand. The doctor wasn't listening, and I went ahead and did the bed weight. I'm there for the patient not the doctor.

Karen stated, "They act like you're not even there and you have to say, "I need to get this order as this is what's going on with my patient." It's like you need to encourage them to speak to you." Jill described an episode of being berated by a physician:

Doctors have to trust us. Even in the hospital setting. A physician didn't think that I knew what was going on with a patient. He berated me. In the nurses' station. I maintained my composure. I didn't respond because I think before I speak, and I didn't want to lose my job. He used harsh words. I wanted to ask him "Would you talk to your mother that way?

Margaret shared, "You are not heard at all by doctors. Whatever I said, they didn't care. That's what they were going to do and you didn't know what you were talking about." Carole shared the following story:

I had to call the doctor on call and ask for a drug. Can I get an order for it? He said no. He called me back 10 minutes later and acted like he had never talked to me and gave me an order for that drug.

The participants shared that their voices were not being heard within the interdisciplinary team. Additionally, the participants stated that administration was oppressive and a barrier to empowerment.

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Hierarchy of administration. During the final step of data analysis, the researcher identified that the participants used hierarchal terms when discussing administration. Participants described administration as being "up there" or "upstairs." Additionally, when discussing administration, the participants frequently called administration "they" or "them." One participant called the administration "the Os." She stated, "You know, the O's. CNO, CFO, CEO. They don't have experience, or recent experience in patient care. They don't have an understanding of what nurses go through. What is needed for patient care." Jill stated, "They aren't in touch with patient care and they'll mandate what you need to do and they don't necessarily understand it takes away from patient care."

Margaret also shared her frustrations with administration. She responded, "There are some folks' upstairs who haven't been downstairs in a very long time. Some of these people are not in the places that need to make this place run the way it needs to be run." Carole answered, "There are some great minds upstairs, but they aren't necessarily in the proper positions. I have seen more people leave out of this building crying because of how they were treated by those upstairs." Jackie responded, "Administration is out of touch. They aren't necessarily in touch with patient care. They'll mandate what you need to do and they don't necessarily understand patient care." The participants viewed the administration as being oppressive. Additionally, the participants shared that they did not have input policies that effect nursing care.

Nurses do not have a voice within the hierarchy. Participants described the concept of nurses "voice." When discussing constraints on nursing practice, the participants shared that the administration is not supportive of nursing and that their

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voices were not being heard.   Jill stated, "Nurses don't have a voice in creating policy. Non-clinicians are creating clinical policy and the system is collapsing." One participant described a procedure for checking patients at night. An electronic method of documentation was being instituted in the hospital. The procedure was complicated and interfered with assessment of the patient. The nurse shared her concerns with the nurse manager who stated, "Don't say that!"   Jackie discussed conflicting mandates:

> They want us to do patient teaching, but the administration says we don't have time to do teaching the way it needs to be done. They said we can't go back and have conversations with the patients. Everything needs to be done at once. There is no time to get all the disciplines together and take it back to the patient. They said there is no time.

Jill shared, "They have taken away critical thinking from nursing. They want everything to be uniform. Patients aren't uniform. They don't hear us when we tell them that." Margaret shared that she is not practicing to her full potential as a nurse. She stated, "I have multiple certifications, but I am not allowed to use them here because they won't let me. They want everybody to do the same thing."

Participants who worked the night shift also reported a lack of "voice." Specifically, Carole described:

> We don't have a voice on night shift. Night shift nurses don't have a voice. We are not heard. Everyone (administration) is gone by the time we get here. All the recognition they get during the day we don't get that at night. They don't know what we do on night shift, so they give us all the paperwork. So, patients don't sleep at night, but we have to take care of them and do all the paperwork.

Karen confirmed that night shift nurses do not have representation. She shared, "We don't have a voice because we don't see the day supervisor and then at night we don't really complain."

Participants shared their concerns over the lack of nursing involvement in developing safe nursing staffing practices. Lynne stated, "I blame the lack of nursing input on low staffing." Another participant supported this assertion: "We are not being heard as far as staffing. You know corporate has a way that they want to staff they do it by numbers, but the numbers don't mean anything if you have a restless patient." Carole stated, "The nurses aren't being heard as far as staffing." When discussing safe staffing practices, Helen stated, "There are a lot of expectations of nurses without a lot of support." Jackie stated:

> The CEO will make me send people home because the staffing is too much because they are trying to make a budget. Health care is a business. They want us to get into the business. I don't think that portion should be combined with health care. It's very chaotic. They don't listen to us. The organization will spend $200 to save $1.00 and it is chaos.

Margaret shared:

> The supervisor will try to get you to take an extra patient. We can't take that patient as there aren't enough nurses. Then it comes the point where a lot of nurses are just scared to lose their job. Do you want to lose this job? No, but you don't want to lose your license if you take that extra patient.

In addition to the oppressive structures of the administrative hierarchy, the participants shared the concept of humbleness as a virtue within the discipline of nursing.

Valuing humbleness. Throughout the narratives, the participants returned to the theme of humbleness within the practice of nursing. This topic first became evident when Jackie discussed her transition from an LPN to an RN. Jackie shared, "I used to want a lot of power. I decided to be humble. I decided I didn't need to be in charge. I just need to take care of my patients." Karen stated, "I don't want to have a lot of accolades because I am not in nursing for that." The participants viewed the need to be humble as an impediment to advancement within the profession. Helen stated that "As a nurse you must be humble. If you are not aggressive or brag, it will hold you back." Carole also identified that being humble was an impediment to advancement. She stated, "I feel like if you document you have something here that says, 'see I did this and that' it shouldn't be a reason you are held out from a position." Jackie stated, "I am just trying to do a good job and not trying to seek praise." The concept of humbleness extended to the evaluation process.

Participants discussed the "exemplar model" of the evaluation process as an oppressive mechanism and contrary to their beliefs of being humble. Jackie stated, "It is oppressing. It makes you not humble. It is difficult to have humility or humbleness when that's what you have to write about yourself and brag. I don't like that. I don't." Karen stated, "If you don't shoot off a rocket or shake the pompoms, then you don't get rewarded. That's the problem with exemplars." Carole also identified that being humble was an impediment to advancement as she was uncomfortable with the exemplar model. She stated, "I feel like if you document you have something here that says, "see I did this and that" it shouldn't be a reason you are held out from a position." Participants identified multiple barriers to empowerment including experiences of racism, the

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hierarchy of the interdisciplinary team, and administration. The participants described

multiple experiences of feeling empowered.

Empowerment Is Being a Voice for Self and Others

"To be empowered, you have to help someone else." (Helen)

The participants defined empowerment as autonomy, working to full potential,

having a voice, and empowering others is empowering to self.   Caring for others,

patients, staff, and nurses was inherent in all the descriptions, definitions, and stories of

empowerment. Advocating for others was threaded throughout all the narratives.

Experiences of autonomy, expert knowledge, and education were identified as

empowerment.

Autonomy, Expert Knowledge, and Education

Jill defined empowerment as having autonomy to care for the patient. "I feel like

it means autonomy. You can make the decisions. The patient is counting on you.

Autonomy." Jill, a former home health nurse supported this assertion with the following:

> All of the cases in home health. You become a part of they're family. You're
>
> connected to the patient. A patient has a wound…and it's not healing, and you try
>
> different things and it's not working. You choose to try different thing I was
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> empowered because I equate empowerment with autonomy. Taking the time to
>
> talk to her we connected. I was helping her and she trusted me. We connected on
>
> a personal level. That was part of my autonomy.

Carole defined empowerment as "Working to your full potential," and Helen stated, "To

be your best. To want to do your best. To become your best with support." Margaret

stated, "To bring my stuff to the table. It means allowing me to do what I do best to take care of the patient."

Furthermore, Jackie identified empowerment as the ability to "Take whatever knowledge you have and use that knowledge to bridge upon to the next step." Margaret stated, "I need to be learning. Empowerment is learning." Marie shared "You're a part of something that makes an impact. Empowerment is learning." Karen asserted, "I believe you can be empowered to keep furthering education." Empowerment arose through autonomy, expert knowledge, and education. In addition, the participants identified empowerment as having a voice.

Having a Voice

While discussing the definition of empowerment, participants identified empowerment as "having a voice." Statements included, "Having a voice and knowing that your voice will be heard." "Having a voice and the ability to impact change. I can do something." Additionally, Karen discussed having a voice and being able to speak openly:

> Empowerment means to me giving a voice, a voice where you are able to speak openly. To feel comfortable to come out and say even the worst thing. To be able to feel like I am needed, that I am appreciated and to have a group of people where I am respected.

Karen identified a time when she felt empowered when night shift nurses became involved in meetings with administration to improve care. She stated, "our voices were heard." In addition to being heard by others, the participants described experiencing empowerment when empowering others.

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Empowering Others is Empowering to Self

The participants identified that empowerment means empowering others. Margaret stated, "I always encourage others. Helping others. Other nurses to become empowered." Jackie stated, "Empowerment means to be in a position where I can help other people with advancement." These statements were supported by Lynne who stated, "Giving someone the tools or facilitating the goals of someone else. You have to empower by helping someone else." This assertion was supported by Helen who described empowerment as something that is passed along. "Empowerment means that you empower me so that I can help to empower them. Empowerment is that you are letting other nurses know they can want more and push people to be their best." Finally, Carolee asserted, "To be empowered, you have to help someone else."

The individual stories demonstrated that empowering others is empowering to self included the recognition that they had a voice to empower others. These stories involved nurses, other staff, and patients. Carole described the concept in terms of voice: "I felt listened to at work. When other nurses come to me and seek guidance and then they can act." Acting as a mediator between others was a time she felt empowered. "My empowerment is when I help nurses talk to each other, be honest, be open. Their voices are heard. I am mediator." Thus, she supported and empowered others. The theme of empowering others was supported by Helen:

> When I became a preceptor, I felt like I was helping other nurses along and I
> could see that they were progressing, and it made me happy. I had one nurse that
> went to another job and she came back and thanked me for all the things that I
> helped her with. That made me feel good. Empowered.

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In addition to mediation and precepting, participants shared stories of empowering others through education. Lynne shared that she found it empowering when she facilitated nurses participating in continuing education. "Now they come to me and ask about CEUs. I look for them and then we attend together." One participant felt empowered when she was teaching an Advanced Cardiac Life Support class. The participant shared, "I was able to facilitate someone having a good experience and they learned new skills. That empowered me." Marie affirmed, "Encouraging others to continue on in their education and advancing in their profession, that's empowering." Thus, encouraging others to continue their education was empowering to the participants. Additionally, providing patient education to empower patients caused the participants to feel empowered.

Karen supported this theme when she described an episode of patient education where she provided a mother with information on medications for her daughter. "I did what I was supposed to do and by doing it the mother felt a lot better about the medications. She understood, and I empowered her to make decisions." Margaret described both patient and nurse education as empowering.

I am empowered when I explain what I am doing to patients and nurses. I am empowered because I am doing what I do best. I can teach someone else how to do something. Then I step back and let them do what I taught. I am going to watch them do it and then let them take off by themselves. That to me is empowerment.

Thus, empowering others was empowering to self. Empowerment occurred through

precepting, mediating, and counselling others. Finally, patient and staff education was

empowering to the participants.

Conclusion

This chapter presented the results from interviews with African American nurses.

Two overarching themes were identified, including (a) oppression is multifaceted and (b)

empowerment is being a voice for self and others. Subthemes were explicated that

supported the overarching themes of the data analysis. Chapter Five will present the

discussion that includes the participants description of their ideal environment and

recommendations for future directions in research, leadership, and education.

CHAPTER V

DISCUSSION

Chapter V will present an overview of the participants' views on an ideal work environment and strategies to create that environment. Additionally, a discussion of the findings will be compared to the literature. Finally, implications for future research, nursing leadership, and nursing education will be presented.

Emancipatory knowing is the reflection and examination of social, cultural, and political injustices. This inquiry provided a critical and in-depth analysis of the participants' situations within the context of the work environment. Through this examination, multiple oppressions were illuminated. Additionally, the participants provided their insights on the concept of empowerment. Furthermore, the participants envisioned an ideal environment where administration is supportive of nurses, nurses have time to care for the patients, and the interdisciplinary team had open communication that allowed for holistic care of patients. Finally, to align with the constructs of emancipatory research, praxis occurred through a discussion of how the participants conceived of creating change within the work environment. Thus, the following research questions are answered in Chapter 5:

1. What are African American nurses' visions of an ideal work environment?

2. How do African American nurses conceive of creating change within the work environment?

Envisioning the Ideal Work Environment

"My voice would be heard." (Karen)

The participants envisioned an ideal work environment where nurses' voices were heard, and nurses had an active role in the development of policies and participated in staffing decisions. Open communication within the interdisciplinary team and respect from team members was emphasized. Finally, lateral violence and incivility were eliminated in the participants' ideal work environment.

Administration in the Ideal Work Environment

Participants ideal work environment was described within the structural empowerment paradigm. The participants identified leadership behaviors and practices that would assist in creating an ideal work environment. These behaviors and practices included open communication, staff having an active role in creating policy, and understanding the role of the nurse. Additionally, in an ideal work environment, the administration would support nurses' staffing requests. The participants also identified administratively-driven efforts to care for nurses. Lastly, administration would help to create a more diverse and equitable work environment where the nurses could remain humble.

Open communication with administrators was key to attaining an ideal work environment. Carole stated, "Administration would have an open door policy and where you are comfortable voicing your opinion without fearing backlash. They would genuinely hear what I am saying." Karen asserted, "My voice would be heard by administration." Having a voice meant participating in decision making and development of policy.

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In the participants' ideal workplace, nurses and staff would be integral to establishing policy. Margaret specified, "In my ideal workplace there would be nurse participation in committees and making policy to make sure my voice is heard." Jill stated, "Nurses creating policy will make sure that theory works in practice. The nurses need to make policy decisions." Carole envisioned an ideal work place that included all team members involved in the development of policy. Carole emphasized that all departments should be involved, saying, "People are empowered and participate in making policy. Everybody is involved. Nursing Housekeeping. Physical Therapy. Maintenance. We all work together. It takes a village." Thus, the entire interdisciplinary team would work together to improve patient outcomes.

In the ideal environment, the participants identified that administration would be familiar with the role of the nurse. Jackie stated, "Administration would be people who have been through the steps, has been working and know how to do the things that we do. They have similar experiences with the staff." Lynne envisioned administrators who were also clinicians who were familiar with the role of nurses. Carole shared this vision: "In my ideal workplace, they (administration) would be educated on what nurses do. They would be more client based. Understand what is need to give care." The participants returned frequently to discuss safe staffing practices and nurses' involvement in decision making regarding staffing patterns.

In addition to administrators possessing clinical experience, all the participants discussed safe nurse staffing patterns. The participants shared that their ideal work environments had adequate nurse staffing and time to "care and nurture the patients." Jackie stated:

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I would have the time to care for my patients. I would know coming in that we

were staffed appropriately for the amount of patients that you have. I have time to

really get report and know what's going on with the patients.

Helen stated, "I would have time to care for the patients. I would have time to teach

patients." Margaret stated, "In my ideal workplace, you wouldn't have to fight to get

staff, so you can take care of the patients." The participants focused on care of the

patient to improve outcomes.

In addition to adequate staffing, the participants all described methods of

nurturing and caring for nurses. Lynne stated that in her ideal work environment: "I

would be able to balance my career and family. All nurses would have mandatory

vacations. Everybody must take a vacation to rest and relax." Additionally, to balance

career and family, Margaret stated, "nurses would manage their own schedule."

Autonomy in scheduling contributed to promoting a work-home balance. Finally,

providing educational opportunities demonstrated caring for nurses.

Participants identified both continuing education opportunities and continuing

their academic education as methods to care for nurses. These opportunities included

learning about their specialty area. Lynne stated, "I would have nurses going to

conferences like other professions. The job would be beyond you are here to work your

schedule." In addition to caring for experienced nurses, Margaret identified the need to

educate new graduates: "In my ideal work setting we would be caring for nurses,

especially new nurses. Teaching them to be nurses or teaching them about the specialty."

Thus, precepting and education was viewed as important to nurture and care for nurses.

In addition to precepting and education, the participants described the need for ongoing education related to cultural diversity.

Finally, the participants envisioned a more equitable and diverse environment. The participants described topics of diversity, equity, and evaluation practices. Carole proposed diversity training for administration to ensure equitable practices that included fair evaluations and disciplinary measures. Margaret stated that in her ideal work environment there would be more recruitment of diverse nurses and more encouragement from administration for diverse nurses to work in specialty areas. Lynne asserted, "More helping with diversity, becoming more integrated. I know that's hard because we just aren't going into nursing." Karen stated that nurses would be "rewarded for our job performance." Jackie stated, "In my Utopia there would be no more exemplars in my evaluation. I can be humble." In addition to equitable environments, the participants described their ideal work place as an environment where everyone works together.

Working with Others

The participants described their ideal environment as a place where professionals worked together as a team with respectful communication. The ideal work environment included nurses openly and effectively communicating with each other. In addition to nurses working as a team, the participants identified open and respectful communication within the interdisciplinary team.

In the ideal work environment, the participants envisioned all nurses working together as a team and communicating appropriately with each other. Helen stated that her ideal work environment had "no confusion created by conflict with each other. Nurses would really listen to each other. There would be no friction." Carole stated, "In

my ideal environment nurses wouldn't criticize each other and would never throw each other under the bus." Karen stated, "Nurses working together to empower each other. Nurses do not criticize each other. Nurses working as a team." This assertion was supported by Jackie who stated, "Nurses would work together as a team. Everyone would be getting along." Jackie continued, "My Utopia is working with other nurses who are team players. We help each other." Helen asserted:

> If there's a conflict. If you are in place where the two of you are talking and you
> can really listen to what each other is saying, then maybe the problem can be
> resolved. People can listen and help and resolve what is going on.

In addition to conflict resolutions, the participants described the virtue of humbleness within the interdisciplinary team.

Two participants stated that nurses would not brag in their ideal workplace. Helen stated, "I would like people not to talk about themselves. To brag. Nurses would be humble." Jackie envisioned a work environment where, "The nurses would never state 'how great I am to my patients'. This is not humble. They would professionally talk about themselves." In addition to nurses working together as a team, the participants also identified interdisciplinary teamwork, which was also described in the ideal work environment.

Communication between nurses and the interdisciplinary team focused on nurse-physician interactions. Carole envisioned physicians communicating appropriately with the nurses. Carole specified, "I would have more training for the doctors on how to communicate." In addition to communicating with physicians, Jill detailed that in her ideal environment all the disciplines communicate effectively:

Everybody communicates with everybody. There would be more cohesiveness

within specialties, so everyone knows what's going on. Everybody can add a

piece to this puzzle. There would be more lines of communication being open.

We can see   everything that is going on. We would have the support of doctors

and all disciplines.

Jackie described the interdisciplinary team in the ideal work environment:

In my ideal workplace there would be collaboration between all members of the

healthcare team to take care of the patient. They would have the opportunity to

spend time with the patient and assess the patient. She (the nurse) would to be

able to communicate the needs of the patient to the entire team. The team

develops a plan of care and then the nurse goes back to the patient and

communicates the plan and provides teaching.

Thus, the participants identified that communication between nurses and between the

interdisciplinary team would help to create the ideal work environment. Finally,

improved communication would contribute to a conflict free work environment and

improve nurse satisfaction and patient outcomes.

Being Active Participants in the Professional Setting

"I am involved." (Helen)

Enhancing structural empowerment was identified as praxis within the

participants' narratives. The participants were asked how they conceived of creating

change in their workplace. Program development, shared governance, participation in

policy development, and mentorship of other nurses were identified as models to create

change. Finally, participation in this inquiry was identified as a method to create change.

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Margaret discussed the potential for program development. She described

creating a program that would be integrated into the workplace for all employees:

I would recommend training for empowerment, teamwork, and communication.

All employees must attend. There would be a plan for rolling out the change to

show that we are serious about teamwork and empowerment. Over one year if

you rolled out different programs, you would need to regroup and see how it's

working. The employees would be kept abreast of what's going on as

communication is key.

Jackie also envisioned program development and implementation. She responded that

she would "write a proposal for a program that would open communication and empower

nurses. I would put down the pros and cons to a program and then try to find a balance

for nurses and administration." Through program development, Jackie envisioned being

an active participant in creating an ideal environment. Furthermore, improving

communication was integral in promoting nurse satisfaction in the participants' ideal

work environments.

Improving communication was reflected in Jill's response that she could conceive

of change by nurses advancing technology to improve communication. Jill commented,

"If there was one computer system that we could all tap into …everyone could see what

was going on. Provide better care to the patient." Thus, communication was not limited

to two team members. Communication crossed institutions to improve patient outcomes.

In addition to communication, the participants recommended participation in

shared governance. Margaret stated, "I am involved with shared governance." This

assertion was also reflected by Karen: "Shared Governance is important. It is the key to

empowering us." In addition to shared governance, Helen asserted, "I would be involved in committees that create policy and procedures would empower nurses." The theme of active involvement and participation was also reflected in meeting the needs of others including nurses and patients.

The participants also shared that they would continue to empower and educate others. Lynne asserted, "I am already creating change. I precept and orient new nurses to our unit." Carole shared, "I will continue to be somebody that you can talk to and fall back on. I will continue to encourage people to continue their education." Encouraging others to continue education and to speak out was also reflected in Karen's statement, "I believe that knowledge is key. People need to continue with their education. I will continue to voice concerns. I will encourage others to speak. You empower others by letting them know that their opinion matters." Thus, advocating and empowering others was viewed as empowering to self.

In addition to the empowering others, two participants identified that participation in this inquiry was helping them to create change. Lynne stated:

Thinking about this research (current interview) I am talking to you because it brings the topic to the forefront. Am I doing this for Black people or is it as a nurse. Who would have known there was a difference in how people are treated. It's like health disparities. Even though I'm Black, I didn't realize there was a difference until the Dean of my nursing school held a seminar. So, let's just say this is a way that I can help make a change.

Jackie responded, "By doing these interviews. I think that it will help make a change. I appreciate being included. I like that we are being nurses and not just race." Through

participation in the research process, participants stated that they felt their voices would be heard.

<div align="center">**Experiencing Oppression**</div>

Experiences of Racism

African American nurses' experiences of racism within the healthcare work environment is well documented throughout the literature. The participants' descriptions of experiences contribute to the growing body of literature. Specifically, participants shared experiences that included the perception of having to work harder than Caucasian nurses, receiving biased evaluations, unfair work assignments, and lack of advancement. Additionally, participants described incidences of being stereotyped as a nurse aide or Licensed Practical Nurse (LPN).

Contrapuntal voices. When listening for contrapuntal voices, the participants moved from using the first person to the frequent use of second person when sharing experiences of oppression. Edwards and Weller (2012) suggested that the change from "I" to "you" reflects the participants' authentic selves. The participants did not use the second person except in describing experiences of oppression. This change in voice was noted most frequently during the narratives related to racism. An example of the change from first person to second person was in the following narrative: "I perceive that I am slighted on my evaluations because I am Black. You hear someone else did a great job and you think 'I did that better.' It is always in the back of your head." The perception of having to work harder due to racial bias is reflective of the participants' narratives.

African American nurses need to work harder. The perception that African American nurses are required to work harder than their Caucasian counterparts

contributes to the growing body of literature of experiences of African American women. Specifically, the perception of needing to be "super woman" is reflected in the disciplines of sociology and psychology. The stereotype of the strong, black woman is embedded in the culture of the United States (Davis, 2014). This stereotype requires that African American women must work harder, be resilient, and self-sufficient. The strong, Black woman stereotype may create a sense of exclusion from Caucasian counterparts (Dow, 2015). Having to be strong and work harder has potentially harmful effects of having to be strong include increase in depression, hypertension, and alcohol use (Watson & Hunter, 2015). Additionally, African American nurses experience pay inequity.

The perception that African American women must work harder compared to their Caucasian counterparts is substantiated in continued pay inequity (DuMonthier, Childers & Milli, 2017; National Council of State Boards of Nursing [NCSBN], 2016). African American women and nurses receive lower pay than their Caucasian counterparts. The perception was also reflected by African American nursing students and nurse leaders (Davis & Moldando-Daniels, 2015; Love, 2009). Additionally, having to work harder, unfair work assignments, and biased evaluations was reflected throughout the literature (Paraway, 2018). Participants shared that they felt they had to work harder than their Caucasian colleagues. In addition to having to work harder, the participants shared that there was a lack of professional advancement due to racial bias.

Participants stated that there was a lack of leadership opportunities for African American nurses. African American women are underrepresented in all leadership positions, and specifically in nursing leadership positions (DuMonthier, Childers & Milli, 2017; NCSBN, 2016). Wesley, Turner, Qaabidh (2011) suggested that this lack of

advancement into leadership positions may be due to the perception that African

American nurses do not possess the skills or knowledge to be successful leaders.

Hickman (2015) labeled the lack of diverse nurse leaders as alarming. Phillips and

Malone (2014) asserted that this underrepresentation negatively impacts the creation of

policy that would aide in recruitment and retention of African American nurses. Despite

the call to increase African American nurses in leadership positions, there is a paucity of

literature related to mentorship and recruitment of African American nurses into

leadership positions apart from nursing faculty. Negative perceptions and stereotyping of

African American nurses may contribute to African American nurses' lack of

advancement.

     Stereotyping. Participants shared multiple experiences of being stereotyped.

Giddings (2005) described experiences of stereotyping of African American nurses and

was reflected in the participants' narratives of being viewed as a nurse aide or licensed

practical nurse. Qaabidh, Wesley, Gulstone, and George-Jackson (2011) asserted

"specific to nurses of African descent, long-standing medical and social practices, in the

middle of the 20th century, leave behind a legacy of group inferiority" (p.3). This

stereotyping can have deleterious effects on African American women including issues

related to depression, hypertension, and diabetes (Jerald, Cole, Ward, & Avery, 2017).

Participants shared experiences of adverse health effects due to racism.

     Many of the participants described multiple experiences of being stereotyped as

an LPN or nurse aide. Furthermore, the participants reported feeling that others

perceived them as not as able to fulfill the requirements of their profession. Stereotyping

was identified as an oppressive structure within the work environment. In addition to stereotyping, African American nurses experienced racism from patients.

Disruptive patients. A review of adjudicated cases revealed that patients who demonstrate racism is an ongoing issue throughout the United States. There is a significant lack of literature or best practices that explicitly address patients who exhibit incivility or refuse care from African American practitioners. Rather, the few journal articles that exist denote patients who are overtly racist as disruptive patients (Jain, 2013). Anecdotal evidence focused on issues of racism toward physicians and recommendations involved managing individual disruptive or antisocial behaviors (Shahriari, Lakdawala, Grant-Kels, 2016). Brady (2014) recognized the disruptiveness of a racist patient in the Post Anesthesia Care Units. The author's recommendations included development of evidence-based policies that specifically address the behaviors, an individualized behavioral plan, involvement of administration early in interventions, and contributions from the facility's ethics committee. Gates and Mark (2012) also recommended clear workplace guidelines and policies that address racism within the workplace. Deacon (2011) recommended that nursing administration develop a culture of support. Participants shared experiences of Caucasian patients refusing care because of racial bias without support from administration. As participants spoke of experiences of racism, they shared their responses to these experiences.

Response to racism. When listening for contrapuntal voices, the researcher noted that immediately after sharing experiences of racism, the participants described their response to racism. Most participants provided the description of coping with racism without prompting from the researcher. Coping with life stressors is situated

within culture (Blackmon, Coyle, Davenport, Owens, & Sparrow, 2016). There is a robust body of literature within the discipline of psychology that addresses African American women's methods of coping with racism. Researchers specifically examined African American women's cognitive and behavioral strategies of coping. Four common strategies include active engagement, spirituality, social support, and avoidance coping (Assari & Lankarani, 2015; Wagstaff, del Carmen, Kim, & Al-Riyami, 2015). The participants described avoidance coping as strategy to manage racism.

Avoidance coping involves cognitive and behavioral actions that minimize, deny, or avoid situations that situations that create stress and is an effective self-protecting coping strategy (Lewis, Williams, Peppers, & Gadson, 2017). The self-protective coping strategy is a deliberate action that seemingly shields against the harmful effects of perceived racism (Szymanski & Lewis, 2015). Specifically, the most common form of avoidance coping is disengagement, desensitization and minimizing experiences (Lewis, Mendenhall, Harwood, & Browne Huntt, 2013; Pearson et al, 2014). This disengagement may also involve ignoring or forgetting the experience (Shahid, Nelson, & Cardemil, 2017). Avoidance coping is considered passive coping as the individual does not directly confront the episodes of racism. Avoidance coping and minimizing experiences was the most common coping strategy discovered in the participant narratives.

. The participants described cognitive efforts to "block out" or minimize the experiences of racism. One participant identified that she attempted to block it out but developed physical manifestations of stress. None of the participants identified spirituality as a method of coping. Contrary to the researcher's personal assumption of the study, the participants did not discuss spirituality throughout the interviews. Rather,

two participants identified that the Church as a patriarchal structure and not inviting to women. One participant identified that social support of other African American nurses was a way to ameliorate experiences of racism and feelings of isolation.

Isolation

Feelings of isolation are documented throughout the literature of experiences of African American nurses and nursing students (Cottingham, Johnson. & Erickson, 2017; Giddings, 2005; Wilson, 2002). Nursing students described feeling like they were living in a salt shaker as there were few African American students in a predominantly Caucasian institution (Love, 2009). Feelings of isolation were evident in many of the interviews. Lynne shared, "You wonder why aren't there more black nurses. Why is there a lack of Black women who want to become nurses?" Marie asked, "Why am I the only one?" Feelings of isolation within the work environment decrease group cohesiveness and may influence potential bullying behaviors in the workplace.

Nurses Oppressing Other Nurses

Nurses frequently experience lateral violence. The Centers for Disease Control (2014) identified nurses as the least powerful group in a healthcare organization, and thus, vulnerable to lateral violence. Lateral violence among nurses is well-documented and is a characteristic of oppressed group behaviors. These behaviors included allocated unreasonable workloads, withholding information, scapegoating, verbal altercations, and gossip (Oyeleye, Hanson, O'Connor, & Dunn, 2013; Roberts, 2000; Taylor, 2016). Racism exhibited by colleagues is also an example of lateral violence described by Likupe, Baxter, Jogi, and Archibong (2016). McNamara (2010) asserted that most nurses have experienced lateral violence. In a survey of nurses (n=1428) participants reported

experiencing lateral violence 997%). Behaviors included name calling, stereotyping, lying, and bullying. Nurses who reported experiencing lateral violence demonstrated increased depression, feelings of hopelessness, and despair (Rainford, Wood, McMullen, & Philipsen, 2014). Lateral violence, including bullying, coworker incivility, and manager incivility was reported by new graduates and leads to decreased work satisfaction, emotional exhaustion, and physical manifestations of stress (Read & Laschinger, 2015; Szutenbach, 2013). The participants experienced lateral violence within the workplace.

The participants described nurses as "throwing each other under the bus" and demonstrating incivility to new graduates. Helen shared that her colleagues gossip about other nurses. Additionally, Jackie identified colleagues who stereotyped African American characteristics. The participant stated, "The nurse asked me if I could swim as Black people don't swim. She also made comments about my hair." In addition to lateral violence, the participants identified age as an oppressive structure.

Age as an Oppressive Structure

The nursing workforce continues to age with 50% of RNs are over the age of 50 (NCSBN, 2016). A review of the literature identified that healthcare organization must retain older nurses as there is a lack of younger nurses to fill positions (Phillips & Miltner, 2014). Additionally, the literature focused on physically adapting units to the aging nurse to improve retention and job satisfaction (Ryan, Bergin, & Wells,2017; Stichler, 2013; Wargo-Sugleris, Wendie, Lane, & Phillips, 2017). However, there is a paucity of literature surrounding ageism in nursing.

Ageism is paradoxical in nursing as the profession identifies experience as beneficial but may be biased against due to perceived inability to physically care for patients or lack of knowledge (Kagan & Melendez-Torres, 2015). Gringart et al (2012) purported that there was a persistent negative stereotype of older nurses that may impact recruiters' decision to hire. Negative stereotyping may be detrimental to the psychological wellbeing of older nurses. These findings were supported by the more experienced participants who asserted that as nurses become older, they are stereotyped as not being able to care for patients or have a lack of knowledge. However, being perceived as too young was also experienced by participants.

Conversely, less experienced nurses reported that being younger was a barrier to empowerment. The participants asserted that physicians and patients do not respect their knowledge due to apparent youth. A paucity of literature exists related to youth and respect in nursing. However, a delimitation of this current study was participants must have at least five years of experience in nursing. This delimitation was identified as nurses with more experience may be more information rich. Furthermore, this delimitation was aligned with Benner's Novice to Expert Model whereby nurses with more experience have developed a mastery of nursing skills (Benner, 1982). In addition to age, the participants shared that sexism caused oppression in the workplace environment.

Being Female as an Oppressive Mechanism.

The profession of nursing is predominantly comprised of women and the act of nursing is known as women's work within a patriarchal society (Dubroski, 2013). The view of nurses deferring to physicians is created by the patriarchal structure of the

healthcare system whereby physicians were traditionally male, and nurses were traditionally female (Ten Hoeve, Jansen, & Roodbol, 2013). The perception of nurses as handmaidens to physicians remains prevalent in media and reinforces the patriarchal hierarchy. Bell, Michalec, and Arenson, (2013) argued that interdisciplinary collaboration is obstructed by the gender roles inherent in the healthcare environment. These assertions were supported by the narratives of the participants. The participants identified that male physicians "talk down" to female nurses and frequently address male nurses rather than female nurses. In addition to gender bias, the participants identified that the hierarchal structure of the interdisciplinary team is oppressive to nurses.

Hierarchal Structures

Hierarchal systems and structures were also identified as barriers to empowerment. The hierarchal structures included the interdisciplinary team and administration. The participants identified a "lack of voice" within both hierarchies.

Hierarchy of the interdisciplinary team. The interdisciplinary team can be viewed as a hierarchy. However, working together as an effective team is essential to improve healthcare outcomes for patients (Price, Doucet, & Hall, 2014). Historically, the social position of physicians has been at the highest place of the hierarchy. A power imbalance is maintained by disruptive communications, including ignoring requests, patronizing statements, and belittling dialogue (Croker, A., Croker, J., & Grotowski, 2014). The potential for sentinel events increases with disruptive communication (Thomson, Outram, Gilligan, & Levett-Jones, 2015). The participants identified multiple incidences of disruptive communications, including belittling, ignoring information, and incivility. Conn, Kenaszchuk, Dainty, Zwarenstein, and Reeves, (2014)

identified that nurses felt isolated from physicians because of the hierarchal relationship although this feeling of isolation could be mediated by healthcare leaders. These findings were substantiated by the participants who reported being ignored and belittled by members of the interdisciplinary team. In addition to the hierarchy within the interdisciplinary team, the participants identified oppression related to the hierarchy of administration.

Hierarchy of administration. Structural empowerment influences nurses' satisfaction. A review of the literature demonstrated that organizations with low structural empowerment have low nurse satisfaction (Kretzschmer et al, 2017; Wong & Laschinger, 2013). Employees who lack the time and resources to complete their work also experience low empowerment. Kanter (1993) asserted that employees who have minimal input into organizational policies are less empowered. Additionally, a lack of understanding of the policies of the organization reduces employee empowerment. The participants identified oppressive structures within the hierarchy of administration. These structures included a lack of resources as defined by high patient-to-nurse ratios. Participants also reported a lack of input into organizational policies. Participants also described evaluation strategies as oppressive. Specifically, the participants viewed the process as requiring them to brag about themselves and not be humble.

Humbleness

The concept of humbleness arose throughout the participant narratives. Demeron (2016) described humbleness as a Christian virtue, meaning that one does not believe that he is better than another person. Crigger and Godfrey (2010) identified that the virtue of humility, while neglected in the literature, is reemerging within the constructs of cultural

humility and positive psychology. Indeed, a review of literature demonstrated a plethora

of research related to these concepts outside of the discipline of nursing. However, there

are few mentions of the virtue of humility or humbleness within the nursing literature.

Only two nursing investigations were identified that explored the concept of humbleness

in nursing.

The virtue of humility in nursing care was described in a qualitative study. de

Vries (2004) described the experiences of nurses' experiences of washing the feet of

patients and illuminated the theme of humility. Within the study, the concept of humility

was identified as "lowly" and "being in the dirt" (p. 582). Although, humbleness may not

just be demonstrated through action. Instead, humbleness may be seen within the

character of a person.

The personal characteristic of humbleness and being other-oriented may improve

patient care. In a qualitative study Pitroff (2013) identified that the virtue of humbleness

provided nurses with the ability to seek interdisciplinary expertise in caring for patients in

palliative care, thereby improving the comfort of the patients.   Humility can be

understood as a character trait, whereby the humble person relates to the world and

others.

The characteristics of humility include accepting criticism. A humble person may

accept criticism in a balanced way without anger (Crigger & Godfery, 2010).

Humbleness may also be operationalized. Humble nurses are not driven by self-interests.

Instead, the humble nurse is other-oriented.

The participants alluded to the concept that humbleness is a virtue. They shared

that creating exemplars for evaluation purposes was oppressive as it did not allow the

person to be humble. The participants shared that bragging was counter to their values.

However, they felt if they did not speak out about themselves, they were held back from

professional advancement. Additionally, the participants asserted that all nurses should

be humble and not "brag" about themselves. The concept of humbleness was intertwined

with structural empowerment in the work environment.

Empowerment and the Ideal Work Environment

The participants intertwined their definitions of empowerment within their visions

of an ideal work environment. Additionally, praxis was initiated through the

identification of steps that participants could take to create the ideal environment.

Manojlovich, (2007) asserted that empowerment of nurses may arise from three

components: (a) a workplace that has the requisite structures to promote empowerment;

(b) a psychological belief in one's ability to be empowered; and (c) acknowledgement

that there is power in the relationships and caring that nurses provide. Critical social

theorists assert that empowerment is a process of uncovering hegemonic structures that

oppress others (Gulbrandsen & Walsh, 2012). Participants described the ideal work

environment, with high structural empowerment and decreased hegemonic structures.

Structural Empowerment

Participants identified structural empowerment as associated with an ideal work

environment. Structural empowerment theorists describe empowerment as power given

to employees by the organization (Kanter, 1993). High structural empowerment is

strongly associated with job satisfaction, commitment to the organization, and retention

of employees (Laschinger, Wong, & Grau, 2013; Wong & Laschinger, 2013). The

participants identified active employment in shared governance as empowering and a

method to creating an ideal work environment. In addition to shared governance and giving empower to employees, nurses must have adequate time to complete their work. Thus, nurses must have appropriate resources to be empowered.

Appropriate resources included time to complete work. Employees must have access to resources, including financial means, time, and opportunities to complete their work (Kretzschmer et al., 2017; Wong & Laschinger, 2013). Organizational structures that impact nurse satisfaction and retention include a reasonable workload and resource availability that are directly related to job strain. The participants identified that staffing challenges were a barrier to empowerment. In their ideal work environment, the participants identified that they would have "time to spend with patients." In addition to adequate resources, nurse autonomy contributes to structural empowerment.

Autonomy and having control over professional practice also improves nurse satisfaction and may positively impact patient care quality (Donahue, Piazza, Griffin, Dykes, & Fitzpatrick, 2008; Wong & Laschinger, 2013). Empowerment related to autonomy was described by Jill, "I feel like it means autonomy. You can make the decisions. The patient is counting on you. Autonomy." Additionally, understanding of the policies of the organization enhances empowerment. The participants envisioned an ideal work environment as having a "voice" and being actively involved in policy development. Finally, information that promotes job expertise is integral to structural empowerment. Participants identified both continuing education opportunities and continuing their academic education as methods to care for nurses in the participants' ideal work environment. In addition to autonomy in practice, the participants described empowerment as feelings of self-efficacy.

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Psychological Empowerment

Psychological empowerment theorists assert that empowerment is complex and arises from internal personality traits interacting with the environment, feelings of self-efficacy, and a process that allows individuals, groups, or organizations to have mastery over their own affairs (Rappaport, 1987; Spreitzer, 1996). The participants defined empowerment within constructs of psychological empowerment. Having expertise and disciplinary knowledge was integral to their descriptions of empowerment. Additionally, autonomy and feelings of self-efficacy were reflected in the participants' definition of empowerment. Active engagement within the work environment was described by the participants.

Active engagement was identified as a method of coping for African American women (Assari & Lankarani, 2015). When listening for contrapuntal voices, it was noted that participants used "I" statements versus "you statements" when identifying methods of creating an ideal environment. Participants were actively engaged in identifying methods of enhancing structural empowerment, decreasing racism, and empowering others. Empowering others demonstrated the power of caring in nursing.

Power in Caring

Manojlovich, (2007) asserted that there is power in the relationships and caring that nurses provide. Relational theory is situated within a feminist philosophy, which emphasizes understanding others and focuses on dialogue. Within the construct of relational theory, relational empowering arises (Fletcher, 2004, 2006). Relational empowerment is the process of enabling others to achieve positive outcomes, including increased knowledge, competence, and self-competence. The person who is empowering

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others provides education based on the learner's needs and may act as a go-between to enhance relationships. The underlying belief of relational empowerment is that power is fluid and alters based on need. The basis for relational empowerment is that there is an interdependence between people (Turner & Maschi, 2015). There was a paucity of research investigating the concept of relational empowering. Williamson (2005, 2007) described a vague description of nurses' ability to empower patients and families in the homecare environment. However, the participants clearly described the concept relational empowerment.

The participants unambiguously described empowerment as empowering others. Relationships with others was situated within this definition. Jill described feelings of empowerment when discussing connectedness with families and patients. Participants described empowerment as empowering others through support, being a go-between, and providing client-based education. Jackie stated, "Empowerment means to be in a position where I can help other people with advancement." These statements were supported by Lynne who specified, "Giving someone the tools or facilitating the goals of someone else. You have to empower by helping someone else." Furthermore, Helen described empowerment as something that is "passed along." In addition to relational empowerment, participants identified structural process and behaviors that oppress African American nurses.

Critical Social Theory and Empowerment

Identifying structures and behaviors that oppress groups is the underlying construct of critical social theory and empowerment. The operational definition of empowerment within this inquiry is a process that occurs through a critical examination

of unequal power structures and hegemonic practices; oppressed or disenfranchised groups may have their voices heard and will ultimately "claim their full human potential" (Chinn & Kramer, 2011, p.84). Critical social theories of empowerment arise from Habermas, Freire, and feminist theories whereby empowerment is a process of uncovering hegemonic structures that oppress others (Gulbrandsen & Walsh, 2012). Specifically, Hill- Collins' (1990, 2000) asserted that through an emerging self-awareness, the woman recognizes power and oppression in her daily life, which leads to changed consciousness. Through self-awareness, the woman is empowered.

Upon conclusion of the interviews, participants identified feelings of relief and empowerment. Janet stated that talking about issues was "cathartic." Carol stated that uncovering the topics of oppression was a "relief." Karen stated, "Talking about all of this felt empowering." The participants clearly identified that the research process itself was empowering and the experiences of African American nurses within the context of the work environment were illuminated.

Implications

The purpose of this inquiry was to explore the experiences of African American nurses within the context of the work environment. This inquiry contributes to the growing body of literature related to African American nurses and structural and psychological empowerment, significant gaps in the literature were identified. Specifically, research related to ageism experienced by nurses and stereotyping of African American nurses was scant. Additionally, no research was identified specifically addressing African American nurses use of coping strategies when faced with racism. A review of the literature revealed scant evidence surrounding the concept of humbleness

and humility and relational empowerment. Thus, future research may focus on nurses and relational empowerment.

Implications for Future Research

As identified in the literature review, stereotype threat has been investigated in relation to healthcare and education. During this inquiry, the participants described the impact of stereotyping on the success of African American nurses within the healthcare system.   Stereotyping negatively-impacted psychological empowerment by reducing feelings of agency or self-efficacy. As this was the first study to illuminate this concept, further research should investigate the concept in more depth. The concept of age bias was illustrated throughout the narratives.

Although there is a significant body of literature related to ageism and the impact of age bias on patients receiving care, there is minimal research investigating aging and ageism within nursing. As 50% of nurses are over the age of 50, this potential bias must be investigated. Future inquiries may explicate the lived experiences of older nurses with a focus on bias, oppression, and empowerment.   Additionally, physical barriers and workplace adaptations may be examined to improve the working conditions of older nurses with inclusion of African American participants. Finally, participants described coping strategies used when confronted with bias.

Coping strategies appeared to be culturally embedded, specifically in response to oppression and racism. Although a strong foundation of knowledge exists related to African American women coping with racism, the literature does not specifically address African American nurses. As this group of women face overt and covert racism daily and there is impact on their clinical practice, future research must focus on supporting the

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coping strategies that protect them from psychological harm. Moreover, supporting

culturally appropriate coping mechanisms can enhance empowerment. Additionally, the

concept of humbleness as a virtue may also be culturally embedded.

The concept of humbleness within nursing practice arose as a new avenue of

research. There is a significant paucity of literature within the discipline of nursing,

related to humility and humbleness. Many of the participants described the need to be

humble. Future research should focus on expanding this concept within nursing as the

participants identified barriers to being humble as oppressive structures. Finally,

relational empowerment was described by participants.

The participants' shared stories of empowering others is empowering to self. In

reviewing the literature, it was noted that this concept is congruent with relational

empowerment. Although described briefly within the discipline of feminist psychology,

the concept of relational empowerment is ill-defined within the literature of nursing.

This concept requires further research, explication, and analysis as the participants clearly

identified that empowering others is empowering to self. Though there are many

implications for future research, there are also implications for leadership practices.

Implications for Nursing Leadership

Implications for administration include strategies to mentor African American

nurses in leadership positions. Administrators and nursing clinicians need to collaborate

on evidence- based strategies to deal with racism within the healthcare environment,

including managing disruptive and racist patients and preventing lateral violence.

Additionally, collaboration between nurses and administration is needed to empower

African American nurses. Thus, there are many implications for leadership practices.

The participants identified implications for leadership. The recommendations focused on active involvement of nurses in programs and policy development. Thus, participatory management practices may increase feelings of empowerment in nursing staff. Additionally, the participants identified the need for cultural education to reduce bias within the workplace. Finally, opportunities for continuing education were recommended. In addition to educational opportunities, African American nurses should be given the opportunity to mentor others.

As African American nurses identified that empowering others is empowering to self, administrators should provide African American nurses opportunities to mentor others. As empowering and caring for patients is empowering to nurses, the nurses should be provided opportunities and time to participate in these activities. Finally, the nurses themselves should be matched with mentors, including African American women in leadership, to promote advancement within the profession. In addition to leadership opportunities, lateral and interdisciplinary aggression must be confronted.

Aggression within the workplace must be addressed. Civility and communication expectations must be clear within the interdisciplinary team and behavioral issues should be addressed. Policies and interventions should focus on preventing lateral aggression. Additionally, methods of reporting incidents of bias and lateral aggression must be developed and implemented to allow for immediate interventions. Finally, clear administrative guidelines must be developed and implemented that address disruptive and racist patients. In addition to implications for research and leadership, the findings of the inquiry have implications for nursing education.

Implications for Nursing Education

Congruent with national nursing education organizations' directives, the participants identified the need to include diversity and cultural competence within nursing education. The National League for Nursing (2015) asserted that diversity and cultural competence are the keystone to nursing education. The participants recommended that cultural competency programs be provided in the workplace setting. This recommendation is transferable to nursing education. Embedding the concepts of cultural competence into curricula, simulation, and clinical experiences encourages nursing students to develop skills that enables them to work with diverse populations, including patients and colleagues. At the baccalaureate level, culturally competent leadership skills must be addressed.

Leadership coursework should include various types of leadership characteristics, including participative management styles. In nursing leadership educational programs, students must be aware of the impact of empowerment on nurse satisfaction. Expectations of civility within the interdisciplinary team should also be emphasized. The significance of this study demonstrated that African American nurses must have a voice within the discipline of nursing to be empowered.

Limitations

Lincoln and Guba (1985) asserted that the ability to transfer research findings and methods from one group to another determines the applicability the findings have on other groups. In this study, a description of the participants was provided, including demographics and geographic boundaries. The findings of this study, however, were not intended to be generalizable to other populations. The intention was to describe a

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specific group of African American nurses' experiences. However, this study does contribute to the growing body of literature of the experiences of African American nurses and may be replicated in other populations. The implications for African American nurses may help direct future research, administration practices, and education.

Conclusion

"We are all nurses." Jackie

> "I think as a whole nursing, should be about all nurses.
>
> I appreciate being included.
>
> I am the only Black nurse here.
>
> I like to keep us all together though, so we are looked at as nurses and not just race.
>
> We are just nurses.
>
> We are all nurses."

APPENDICES

APPENDIX A

INVITATION LETTER

Dear Potential Participant:

My name is Laurie Pierce and I am a PhD student in the College of Nursing and Professional Disciplines at the University of North Dakota. I am inviting you to participate in a research project. The purpose of the proposed project is to explore African American nurses' perceptions of professional experiences within the context of the healthcare environment. This research can benefit nursing by aiding in identification of processes that promote African American nurses' empowerment within the work environment. The outcomes of this research may influence education, policy, and practice for African American nurses.

The proposed inquiry is emancipatory in nature, where I am asking participants to explore your experiences of empowerment and the work environment. Should you choose to participate, I will conduct an interview with you and the interview will take one to two hours. I will ask you about your experiences in the healthcare work environment. I will ask you to describe your ideal work environment, and, finally, I will ask what empowerment means to you.

I am asking that participants be Registered Nurses, with a highest degree at the Bachelor's level, working in acute care, long term care, or rehabilitation settings. Participants should have at least five years of experience as a Registered Nurse and not be Advanced Practice Nurses or nurse managers.

The interview will last for approximately an hour. We can meet at a location convenient for you or by telephone. This location may be a library or other quiet and comfortable place that we can speak uninterrupted. There is not a fee to participate.

If you are interested in participating in this research, please call or email me.

Laurie Pierce, RN, MSN

APPENDIX B

PARTICIPANT DEMOGRAPHICS

Participant Demographic Information

Participant: _____ (number)

1. Self-identified as an African American registered nurse   Yes _____   No_____
   (if no, do not continue)

2. Years of experience working as a Registered Nurse   _____ (if less than five years,
   do not continue)

3. Completed Level of Education   ASN/ADN _____   Diploma_____ BSN_____

4. Educational degrees outside of nursing _____

5. Specialty Nursing Roles (example: Med/ Surg, ICU, Long Term Care)_____

6. Role experiences: (example: floor nurse, nurse manager, nurse educator, case
   manager)   _____

7. Work Status: _____

APPENDIX C

INTERVIEW QUESTIONS

Research Questions	Semi structured Interview Questions
What is it like to be an African American nurse in a predominantly White profession?	Tell me how you became interested in nursing? (ice breaker). What is it like to be an African American nurse in a predominantly White profession?
What are the perceived power structures that affect African American nurses within the work environment?	What are the power structures that affect your work as an African American nurse? Are there power structures within your work environment? Are there power structures outside of your work environment? How do these power structures affect your work?
What are African American nurses' subjective experiences of empowerment?	Tell me about what the term empowerment means to you? Tell me about a time you felt empowered. What barriers do you see to the process of empowerment? What supports do you see to the process of empowerment?
How do African American nurses conceive of making changes to create an ideal work environment in which they feel empowered?	Let's imagine the ideal work environment in which you felt empowered. Please tell me how you envision this work environment. What efforts have you already made to create a more empowering work environment? How successful were those efforts? What are the steps you could take to create an ideal work environment in which you feel empowered? How can this research, or I as a researcher, help create this change?

CONSENT FORM

THE UNIVERSITY OF NORTH DAKOTA
CONSENT TO PARTICIPATE IN RESEARCH

TITLE: *Exploring the Experiences of African American Nurses: An Emancipatory Inquiry*

PROJECT DIRECTOR: *Laurie Pierce, RN MSN PhD Student*

PHONE #

DEPARTMENT: *Department of Nursing*

STATEMENT OF RESEARCH

A person who is to participate in the research must give his or her informed consent to such participation. This consent must be based on an understanding of the nature and risks of the research. This document provides information that is important for this understanding. Research projects include only subjects who choose to take part. Please take your time in making your decision as to whether to participate. If you have questions at any time, please ask.

WHAT IS THE PURPOSE OF THIS STUDY?

You are invited to be in a study about the experiences of African American nurses within the context of the work environment. The purpose of this research study is to explore the experiences of empowerment of African American nurses. The existing literature does not include an examination of empowerment of African American nurses, nor is there collaboration between researchers and African American nurses that assist in the process of improving the circumstances of African American nurses within the context of the healthcare work environment.

HOW MANY PEOPLE WILL PARTICIPATE?

Approximately two people will be interviewed to complete this study.

HOW LONG WILL I BE IN THIS STUDY?

Your participation in the study will last approximately one to two hours for one face to face interview or telephone interview. The face to face interviews will occur in a place mutually determined by you and the researcher. The chosen location must allow for an undisturbed discussion.

WHAT WILL HAPPEN DURING THIS STUDY?

You and the researcher will meet for an interview at a place mutually determined by you and the researcher or by telephone. The place of the interview must be quiet and provide uninterrupted time for the interview. The researcher will ask questions related to work circumstances and experiences of empowerment. The interview will last approximately one to two hours. Notes will be taken during the interview.

WHAT ARE THE RISKS OF THE STUDY?

There may be some risk from being in this study. It may be uncomfortable to talk about past life events. Discussing past life events may cause emotional distress. However, such risks are not viewed as being in excess of "minimal risk."

If, however, you become upset by questions, you may stop at any time or choose not to answer a question. If you would like to talk to someone about your feelings about this study, you are encouraged to contact your local medical center. No commitment, however, is made by the University of North Dakota to provide free medical care or money for treatment.

WHAT ARE THE BENEFITS OF THIS STUDY?

You may not benefit personally from being in this study. However, we hope that, in the future, other people might benefit from this study because the findings may influence policy, education, and administration.

ALTERNATIVES TO PARTICIPATING IN THIS STUDY

The alternative is to participating is to not to take part in the study. The participant is free to refuse to take part in this study, to refuse to answer questions, and to discontinue participation at any time without affecting the relationship with the researcher.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

You will not have any costs for being in this research study other than time involved in the study and possible travel to a mutually determined place for interviews.

WILL I BE PAID FOR PARTICIPATING?

You will not be paid for being in this study.

WHO IS FUNDING THE STUDY?

The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this study.

CONFIDENTIALITY

The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies, the UND Research Development and Compliance office, and the University of North Dakota Institutional Review Board

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. As the researcher is a mandatory reporter, you should know, however, that there are some circumstances in which we may have to show your information to other people. For example the law may require us to show your information to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

Confidentiality will be maintained by means of assigning a participant pseudonym. All participant identifiers will be removed from field notes and transcripts and be labeled with a participant pseudonym. All transcriptions, field notes, and research journals will be kept in a locked drawer in a locked office. Only the researcher and the dissertation committee will have access to the field notes and transcripts. In addition, computer files will be password protected. Access to computer files and other sensitive information will be limited to the researcher and the dissertation committee. Any identifying written data will be destroyed after three years commencing upon completion of the dissertation.

If we write a report or article about this study, we will describe the study results in a summarized manner so that you cannot be identified.

IS THIS STUDY VOLUNTARY?

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with the University of North Dakota

If you decide to leave the study early, we ask that you *notify the researcher by telephone or email.*

You will be informed by the research investigator of this study of any significant new findings that develop during the study which may influence your willingness to continue to participate in the study.

CONTACTS AND QUESTIONS?

The researcher conducting this study is Laurie Pierce. You may ask any questions you have now. If you later have questions, concerns, or complaints about the research please contact Laurie

Pierce during the day and at 814-670-0373 or at a time convenient to you. The researcher's email is laurie.pierce@my.und.edu.

The researcher's advisor is Dr. Gayle Roux. You can contact her at 701 777 4522.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at (701) 777-4279.

- You may also call this number about any problems, complaints, or concerns you have about this research study.
- You may also call this number if you cannot reach research staff, or you wish to talk with someone who is independent of the research team.
- General information about being a research subject can be found by clicking "Information for Research Participants" on the web site: http://und.edu/research/resources/human-subjects/research-participants.cfm

I give consent for my quotes to be used in the research; however I <u>will not</u> be identified.

Please initial: **____ Yes** **____ No**

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subjects Name: _____

_____ _____
Signature of Subject   Date

I have discussed the above points with the subject or, where appropriate, with the subject's legally authorized representative.

_____ _____
Signature of Person Who Obtained Consent   Date

REFERENCES

Adriaenssens, J., Hamelink, A., & Bogaert, P. (2017). Predictors of occupational stress
and well being in first-line nurse manages: A cross-sectional survey study.
International Journal of Nursing Studies, 73, 85-92.
https://doi.org/10.1016/j.ijnurstu.2017.05.007

Agency for Healthcare Research and Quality [AHRQ]. (2013). *National Healthcare
Disparities Report, 2013.* Retrieved from
http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/chap2.html#cvd

Agger, B. (1991). Critical social theory, post structuralism, post modernism: Their
sociological relevance. *Annual Review of Sociology*, 17, 105-131.

Alexander-Delpech, P. (1997). I*n investigation into the lived experiences of racism
among African -American nurses*. (Unpublished doctoral dissertation). Barry
University, Miami, FL.

Allen, D. G. (2006). Whiteness and difference in nursing. *Nursing Philosophy, 7*, 65-78.
Retrieved from http://ezproxy.undmedlibrary.org/login?url=http://
search.ebscohost.com.ezproxy.undmedlibrary.org/login.aspx?direct=true&AuthT
ype=ip,url,uid,cookie&db=c8h&AN=2009212404&site=ehost-live

American Association of Colleges of Nursing. [AACN]. (2017). *Diversity, inclusion, &
equity in academic nursing.* Retrieved from http://www.aacnnursing.org/News-
Information/Position-Statements-White-Papers/Diversity

American Association of Colleges of Nursing. [AACN]. (2015). *Enhancing diversity in the workforce.* Retrieved from http://www.aacnnursing.org/News-Information/Fact-Sheets/Enhancing-Diversity

American Association of Colleges of Nursing. (2012). *Nursing shortage.* Retrieved from http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage

American Psychological Association [APA]. (2014*). Fact sheet: Health disparities and stress.* Retrieved from http://www.apa.org/topics/health-disparities/fact-sheet-stress.aspx

Anderson, J. M. (2014). Social justice: Continuing the dialogue. In P. N. Kagan, M. C. Smith, & P. L. Chinn (eds.). *Philosophies and practices of emancipatory nursing,* (pp. IX-X). New York, NY: Routledge.

Armstrong, K., Putt, M., Halbert, C.H., Grande, D., Schwartz, J.S. Liao, K.,…Shea, J.A.(2013). Prior experiences of racial discrimination and racial differences in health care system distrust. *Medical Care, 51*, 144-150. doi:10.1097/MLR.0b013e31827310a1

Assari, S., & Lankarani, M. M. (2016). Association between stressful life events and depression. Intersection of gender and race. *Journal of Racial and Ethnic Disparities, 3*, 349-356. doi:10.1007/s40615-015-0160-5

Ayalon, L., & Gum, A. M. (2011). The relationships between major lifetime discrimination, everyday discrimination, and mental health in three racial and ethnic groups of older adults. *Aging & Mental Health, 15*, 587-594. doi:10.1080/13607863.2010.543664

Bailey, S., & Handu, D. (2012). *Introduction to epidemiologic research methods in public health practice.* Sudbury, MA: Jones and Bartlett.

Bandura, A. (1997). Insights. Self-efficacy. *Harvard Mental Health Letter, 13*, (9) 4-6.

Banks, J. (2014). "And that's going to help Black women how?" Storytelling and striving to stay true to the task of liberation in the academy. In P. N. Kagan, M. C. Smith, & P. L. Chinn (eds.), *Philosophies and practices of emancipatory nursing,* (pp. 124-135). New York, NY: Routledge.

Battle v. Hurley Hospital. (2013). CD 13-997630-Circuit Court County of Genesee 2013. Retrieved from http://www.freep.com/assets/freep/pdf/C4201054218.PDF

Beatty, D. L., Hall, M. H., Kamarck, T. A., Buysse, D. J., Owens, J. F., Reis, S. E., & Matthews, K. A. (2011). Unfair treatment is associated with poor sleep in African American and Caucasian adults: Pittsburgh SleepSCORE project. *Health Psychology, 30*, 351-359. doi:10.1037/a0022976

Bell, A.V., Michalec, B., & Arenson, C. (2013). The (stalled) progress of interprofessional collaboration: The role of gender. *Journal of Interprofessional Care, 28*(2), 98-102. doi:10.3109/13561820.2013.851073

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice* (commemorative edition). Upper Saddle River, NJ: Prentice Hall Health.

Benner, P. (1982). From novice to expert. *The American Journal of Nursing, 82,* 402-407. Retrieved from http://www.healthsystem.virginia.edu/pub/therapy-services/3%20-%20Benner%20-%20Novice%20to%20Expert-1.pdf

Blackmon, S. M., Coyle, L. D., Davenport, S. D., Owens, A. C., & Sparrow, C. S. (2016).

    Linking racial and ethnic socialization to culture and race-specific coping among

    African American college students. *Journal of Black Psychology, 42,* 549-576.

    doi:10.1177/0095798415617865

Boormann, L., & Abrahamson, K. (2014). Do staff nurse perceptions of nurse leadership

    behaviors influence staff nurse job satisfaction? The case of a hospital applying

    for Magnet® Designation. *Journal of Nursing Administration*, *44*, 219-225.

    doi:10.1097/NNA.0000000000000053

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2008). Power and empowerment in

    nursing: A fourth theoretical approach. *Journal of Advanced Nursing, 62*, 258-

    266. doi:10.1111/j.1365-2648.2008.04598.x

Brady, J. M. (2014). The racist patient-revisited. *Journal of Perianesthesia Nursing, 29,*

    239-241. https://doi.org/10.1016/j.jopan.2014.03.008

Breau, M., & Rhaume, A. (2014). The relationship between empowerment and work

    environment on job satisfaction, intent to leave, and quality of care

    among ICU nurses. *Dynamics, 25*, 16–24.   Retrieved from

    https://dev.caccn.ca/en/members/archives:_dynamics:_the_official_journal_/index

    .html Broussard, L. (2007). Empowerment in school nursing practice: A grounded

    theory approach. *Journal of School Nursing, 23*, 322-328.

    doi:10.1177/10598405070230060401

Browne, K. (2005). Snowball sampling: Using social networks to research non-

    heterosexual women. *International Journal of Social Research Methodology*, *8*,

    47-60. doi:10.1080/1364557032000081663

Burgess, D. J., Warren, J., Phelan, S., Dovdio, J., & van Ryn, M. (2010). Stereotype

    threat and health disparities: What medical educators and future physicians need

    to know. *Journal of General Internal Medicine, 25,* 169-177. doi:10.1007/s11606-

    009-1221-4

Campesino, M., Saenz, D. S., Choi, M., & Krouse, R. D. (2012). Perceived

    discrimination and ethnic identity among breast cancer survivors. *Oncology*

    Nursing Forum, 39, E91-E100. doi: 10.1188/12.ONF.E91-E100

Carnegie, E., & Krieger, A. (2009). Being and doing politics: An outdated model or 21st

    century reality? *Journal of Advanced Nursing, 65,* 1976-1984.

    doi:10.1111/j.1365-2648.2009.05084.x

Carnegie, M. E. (2000). *The path we tread: Blacks in nursing worldwide*. Sudbury, MA:

    Jones and Bartlett.

Carper, B. S. (1978). Fundamental patterns of knowing in nursing. *Advances in*

    Nursing Science, 1, 13-24. Retrieved from

    https://journals.lww.com/advancesinnursingscience/Citation/

    1978/10000/Fundamental_Patterns_of_Knowing_in_Nursing.4.aspx

Carthon, J. M. (2011). Life and death in Philadelphia's black belt: A tale of an urban

    tuberculosis campaign, 1900-1930. *Nursing History Review, 19*, 29-52.

    doi:10.1891/1062-8061.19.29

Centers for Disease Control [CDC]. (2018*). Prevention strategies for seasonal influenza*

    in healthcare settings. Retrieved from https://www.cdc.gov/flu/professionals/

    infectioncontrol/healthcaresettings.htm

Centers for Disease Control Office of Minority Health. (2014). *Disease burdens and risk*

    factors. Retrieved from http://www.cdc.gov/omhd/amh/dbrf.htm

Centers for Disease Control [CDC]. (2014). *Workplace violence prevention for nurses.*

    Retrieved from http://wwwn.cdc.gov/wpvhc/Course.aspx/Slide/Unit4_7

Centers for Disease Control [CDC], (2013). *CDC health disparities and inequality*

    report. Retrieved from http://www.cdc.gov/minorityhealth/

    CHDIReport.html#Intro

Chandler, G. E. (1992). The source and process of empowerment. *Nursing Administrative*

    Quarterly, 16, 65-72. Retrieved from http://journals.lww.com/naqjournal/

    Citation/1992/01630/The_source_and_process_of_empowerment_.11.aspx

Chaney v. Plainfield Healthcare Center, 612 F. 3d 908 (U.S. Ct. App. 2010)

    Retrieved from http://scholar.google.com/scholar_case?case=

    12175147218935997244

Chen, D., & Yang, T. (2014). The pathways from perceived discrimination to self-rated

    health: An investigation of the roles of distrust, social capital, and health

    behaviors. *Social Science & Medicine, 104*, 64-73.

    doi:10.1016/j.socscimed.2013.12.021

Chinn, P. L. (2001). *Peace and power: Building communities for the future*. Boston, MA:

    Jones and Bartlett.

Chinn, P. L., & Kramer, M. K. (2011). *Integrated theory and knowledge development in*

    nursing (8th ed.). St. Louis, MO: Mosby.

Clements, P. T., & Averill, J. B. (2004). Patterns of knowing as a method of assessment and intervention for children exposed to family member homicide. *Archives of Psychiatric Nursing 18,*143-150. http://dx.doi.org/10.1016/j.apnu.2004.05.006

Cohen, J. (2009). Providing a healthy work environment for nurses: The influence on retention. *Journal of Nursing Care Quality, 24,* 308. doi:10.1097/NCQ.0b013e3181a4699a

Conger, J. A., & Kanungo, R. N. (1988). The empowerment process: Integrating theory and practice. *Academy of Management Review,13*, 471-482. Retrieved from http://www.jstor.org/stable/258093?seq=1#page_scan_tab_contents

Conn, L.G., Kenaszchuk, C., Dainty, K., Zwarenstein, M., & Reeves, S. (2014). Nurse-physician collaboration in general internal medicine: A synthesis of survey and ethnographic techniques. *Health and Interprofessional Practice, 2,* (2)1-14. https://doi.org/10.7772/2159-1253.1057

Corbally, M. A., Scott, P. A., Matthews, A., Gabhann, L. M., & Murphy, C. (2007). Irish nurses' and midwives' understanding and experiences of empowerment. *Journal of Nursing Management, 15*, 169-179. doi:10.1111/j.1365-2834.2007.00626.x

Corrigan, P.W., Pickett, S., Schmidt, A., Stellon, E., Hantke, E., Kraus, D., & Dubke, R. (2017). Peer navigators to promote engagement of homeless African Americans with serious mental illness in primary care. *Psychiatry Research*, *255*, 101–103. http://doi.org/10.1016/j.psychres.2017.05.020

Cottingham, M. D., Johnson, A. H., & Erickson, R. J. (2017). "I can never be too comfortable:" Race, gender, and emotion at the hospital bedside. *Qualitative Health Research, 28,* 145-158. https://doi.org/10.1177/1049732317737980

Cowling, W. R, Chinn, P. L., & Hagedorn, S. (2000, 2009). *A nursing manifesto: A call to conscience and action.* Retrieved from https://nursemanifest.com/research/2003-study/

Crigger, N., & Godfrey, N. (2010). The importance of being humble. *Advances in Nursing Science, 33,* 3010-319. doi:10.1097/ANS.0b013e3181fb2e8c

Croker, A., Croker, J., & Grotowski, M. (2014). Changing directions in health care. In J. Higgs, A. Croker, D. Tasker, J. Hummell, & N. Patton (Eds.), *Health practice relationships* (pp. 27-36). Rotterdam, The Netherlands: Sense Publishers.

D'Antonio, P. (2012). *American nursing: A history of knowledge, authority, and the meaning of work.* Baltimore, MD: The Johnsons Hopkins University Press.

D'Antonio, P., & Whelan, J. C. (2009). Counting nurses: The power of historical census data. *Journal of Clinical Nursing, 18,* 2717-2724. doi:10.1111/j.1365-2702.2009.02892.x

Danzer, G. (2012). African-Americans' historical trauma: Manifestations in and outside of therapy. *Journal of Theory Construction & Testing, 16*, 16. Retrieved from http://connection.ebscohost.com/c/articles/75165742/african-americans-historical-trauma-manifestations-outside-therapy

Davis, A. T. (1999). *Early Black American leaders in nursing: Architects for integration and equality.* Sudbury, MA: Jones and Bartlett.

Davis, D. R., Maldonado-Daniels, C. (2015). Shattering the glass ceiling: The leadership

    development of African American women in higher education. *Advancing Women*

    in Leadership Journal, 35, 48-64. Retrieved from

    http://www.advancingwomen.com/awl/Vol35_2015/ Davis_Shattering _

    the_Glass_Ceiling.pdf

Davis, S. M. (2014). The "strong Black woman collective": A developing theoretical

    framework for understanding collective communication practices of Black

    women. *Women's Studies in Communication, 38,* 20-35.

    doi:10.1080/07491409.2014.953714

Deacon, M. (2011). How should nurses deal with patients' personal racism? Learning

    from practice. *Journal of Psychiatric and Mental Health Nursing, 18*, 493-500.

    doi:10.1111/j.1365-2850.2011.01696.x

Dameron, C. (2016). Humility: A noun, adjective, and a verb? *Journal of Christian*

    Nursing, 333, 1-9. doi:10.1097/CNJ.0000000000000234

de Vries, K. (2004). Humility and its practice in nursing. *Nursing Ethics, 11,* 577-586.

    doi:10.1191/0969733004ne740oa

Dittmer, J. (2017). *The good doctors: The medical committee for human rights and the*

    struggle for social justice in health care. Jackson, MS: University Press of

    Mississippi.

Doane, G. H. (2014). Cultivating relational consciousness in social justice practice. In P.

    N. Kagan, M. C. Smith, & P. L. Chinn (eds.), *Philosophies and practices of*

    emancipatory nursing, (pp. 124-135). New York, NY: Routledge.

Donahue, M. O., Piazza, I. M., Griffin, M. Q., Dykes, P. C., & Fitzpatrick, J. J. (2008).

    The relationship between nurses' perceptions of empowerment and patient

    satisfaction. *Applied Nursing Research, 21,* 2-7. doi:10.1016/j.apnr.2007.11.00.1

Dow, D. M. (2015). Negotiating "The welfare queen" and "The strong Black woman"

    African American middle-class mothers' work and family perspectives.

    Sociological Perspectives, 58, 36-66. https://doi.org/10.1177/0731121414556546

Dubois, W. E. B. (1935). *Black reconstruction in American: 1860-1880.* New York:

    Harcourt Brace.

Dubrosky, R. (2013). Iris Young's five faces of oppression applied to nursing. *Nursing*

    Forum, 48, 205–210. doi:10.1111/nuf.12027

Dunphy, L., & Longo, J. (2010). Postmodern philosophy and qualitative research. In P. L.

    Munhall (Ed.), *Nursing research: A qualitative perspective* (5th ed.), (pp. 95-

    107). Sudbury, MA: Jones & Bartlett.

DuMonthier, A., Childers, C., & Milli, J. (2017). *The status of Black women in the United*

    States. Retrieved from https://www.domesticworkers.org/sites/default/

    files/SOBW_report2017_compressed.pdf

Edwards, R., & Weller, S. (2012). Shifting analystic ontology: Using I-poems in

    qualitative research. *Qualitative Research, 12,* 202-217.

    doi:10.1177/1468794111422040

Evans-Agnew, R. A., Sanon, M., & Boutain, D. M. (2013). Critical research

    methodologies and   social justice issues: A methodological example using

    photovoice. In P. N. Kagan, M. C. Smith, & P. L. Chinn (eds.), *Philosophies and*

    practices of emancipatory nursing, (pp. 124-135). New York, NY: Routledge.

Fawcett, J., Watson, J., Neuman, B., Walker, P. H., & Fitzpatrick, J. J. (2001). On

    nursing theories and evidence. *Journal of Nursing Scholarship, 33,* 115-119.

    Retrieved from https://sigmapubs.onlinelibrary.wiley.com/doi/ full/10.1111 /

    j.1547-5069.2001.00115.x

Field, A. (2011). *Discovering statistics using SPSS*. (3rd. ed.). Los Angeles, CA: Sage

    Press.

Flick, U. (2014). *An introduction to qualitative research* (5th ed). Thousand Oaks, CA:

    Sage.

Fontana, J. S. (2004). A methodology for critical science nursing. *Advances in Nursing*

    Science, 27, 93-101. Retrieved from https://journals.lww.com/

    advancesinnursingscience/ Abstract/2004/04000/A_ Methodology_for_

    Critical_Science_in_Nursing.3.aspx

Fletcher, J. (2006). Beyond dualism: Leading out of oppression. *Nursing Forum, 41*, 50-

    59. doi:10.1111/j.1744-6198.2006.00039.x

Fletcher, J. (2004). Relational theory in the workplace. In J.V. Jordon & M. Walker's

    Complexity of connection: Writing from the Stone Center's Jean Baker Miller

    Training Institute. New York: Guilford Press

Frankel, R. M., McGuire, T. G., Zaslavasky, A. M., Lafata, J. E., & Tai-Seale, M. (2017).

    Patient and physician race and the allocation of time and patient engagement

    efforts to mental health discussions in primary care: An observational study of

    audiorecorded periodic health examinations. *The Journal of Ambulatory Care*

    Management, 40, 246-256. doi:10.1097/JAC.0000000000000176

Freire, P. (2014). *Pedagogy of the oppressed: 30th Anniversary edition*. New York, NY: Bloomsbury.

Freire, P. (1970). *Pedagogy of the oppressed*. New York, NY: Seabury Press.

Freundlieb, D. (2000). Rethinking critical theory: Weakness and new directions. *Constellations, 7,* 80-99. doi:10.1111/1467-8675.00171

Fryer, K. (2009). *African American nurses: A phenomenological study of African American nurses' stay in the profession* (Doctoral dissertation). Retrieved from ProQuest. Order Number 3381071.

Fulton, Y. (1997). Nurses' views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing, 26*, 529-536. doi:10.1046/j.1365-2648.1997.t01-13-00999.x

Fujishiro, K. (2009). Is perceived racial privilege associated with health? Findings from the behavioral risk surveillance system. *Social Science and Medicine, 68,* 840-844. doi:10.1016/j.socscimed.2008.12.007

Gates, M. G. & Mark, B. A. (2012). Demographic diversity, value congruence, and workplace outcomes in acute care. *Research in Nursing & Health, 35*, 265-276. doi:10.1002/nur.21467.

Gibson, C. H. (1991). A concept analysis of empowerment. *Journal of Advanced Nursing, 16,* 354-361. doi:10.1111/j.1365-2648.1991.tb01660.x

Giddings, L. S. (2005). Health disparities, social injustice, and the culture of nursing. *Nursing Research, 54*, 304-312. Retrieved from http://journals.lww.com/nursingresearchonline/Abstract/2005/09000/Health_Disparities,_Social_Injustice,_and_the.4.aspx

Giger, J. N., & Davidhizar, R. (1997). Reflection on the elderly African American in

   health care. *Journal of Cultural Diversity, 4,* 88-94. Retrieved from

   https://www.questia.com/library/p587/journal-of-cultural-diversity

Gilligan, C., Spencer, R., Weinberg, M. K., & Bertsch, T. (2003). On the listening guide:

   A voice-centered relational method. In P. M. Camic, J. E. Rhodes, & L.Yardley

   (eds*.), Qualitative research in psychology: Expanding perspectives in*

   methodology and design (pp. 157-172). Washington, DC: American

   Psychological Association.

Gipson-Jones,T. (2009). Perceived work and family conflict among African American

   nurses in college. *Journal of Transcultural Nursing, 20,* 304-312.

   doi:10.1177/1043659609334849

Gipson-Jones, T. (2005). *Relationship between work/family conflict, job satisfaction,*

   psychological well being among African American nurses. (Unpublished doctoral

   dissertation). Hampton University, Hampton, VA.

Goedhart, N. S., van Oostveen, C., & Vermeulen, H. (2017). The effect of structural

   empowerment of nurses on quality outcomes in hospitals: A scoping review.

   Journal of Nursing Management, 25, 1954-206.

   http://dx.doi.org/10.1111/jonm.12455

Goldstein, R. (1960). Negro nurses in hospitals. *The American Journal of Nursing, 60,*

   215-217. Retrieved from http://journals.lww.com/ajnonline/Abstract/ 1960/

   02000/Negro_Nurses_in_Hospitals_.31.aspx

Gringart, E., Jones, B., Helmes, E., Jansz, J., Monterossa, L., & Edwards, M. (2012).

    Negative stereotyping older nurses despite contact and mere exposure: The case

    of nursing recruiters in western Australia. *Journal of Aging Social Policy, 24,*

    400-416. doi:10.1080/08959420.2012.735170

Gulbrandsen, C. L., & Walsh, C. A. (2012). It starts with me: Women mediate power

    within feminist activism. *Women and Social Work, 27*, 275-288.

    doi:10.1177/0886109912452640

Habermas, J. (1979). *Communication and the evolution of society* (T. McCarthy, Trans.).

    Boston, MA: Beacon Press.

Habermas, J. (1973). *Theory and practice* (J. Viertel, Trans.). Boston, MA: Beacon Press.

Hall, J. M., & Fields, B. (2013). Continuing the conversation in nursing on race and

    racism. *Nursing Outlook, 61,* 164-173. doi:10.1016/j.outlook.2012.11.006

Harris v. The Queen's Medical Center. (2018). Retrieved from

    http://hoohiki.courts.hawaii.gov/#/case?caseId=1CC131001737

Hesse-Biber, S. D. (2012). Feminist research: Exploring, interrogating, and

    transforming the interconnections of epistemology, methodology, and method.

    In S.D. Hesse-Biber (Ed*.), Handbook of Feminist Research **T**heory and Praxis*

    (2nd ed.) (pp.2-26). Boston, MA: Sage.

Hickman, R. (2015). Sustaining nursing diversity in clinical settings: Leadership and

    minority nurses, presented at 43rd Biennial Convention Sigma Theta Tau

    International, Las Vegas, NV, 2015. Indianapolis, IN: Sigma Theta Tau

    International.

Hill-Collins, P. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). New York, NY: Routledge.

Hill-Collins, P. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment.* New York, NY: Routledge.

Hine, D. C. (1988). "They shall mount up with wings as eagles:" Historical images of Black nurses, 1850-1950. In A. H. Jones (Ed.), *Images of nurses: Perspectives from history, art, and literature*. Philadelphia, PA: University of Pennsylvania Press.

Ibrahim, M. M., El-Magd, M. H., & Sayed, H.Y. (2014). Nurse's psychological empowerment and perceived autonomy in university and teaching hospitals at Menofia Governorate/Egypt. *Journal of Nursing Education and Practice, 4* (9). https://doi.org/10.5430/jnep.v4n9p59

Institute of Medicine of the National Academies [IOM]. (2010). *The future of nursing: Leading change, advancing health.* Retrieved from http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

Jacobs, B. B., Fontana, J. S., Kehoe, M. H., Matarese, C., & Chinn, P. L. (2005). An emancipatory study of contemporary nursing practice. *Nursing Outlook, 53*, 6-14. doi:10.1016/j.outlook.2004.04.015

Jain, S. H. (2013). The racist patient. *Annals of Internal Medicine, 158*, 632. doi:10.7326/0003-4819-158-8-201304160-00010

Jerald, M. C., Cole, E. R., Ward, L. M., & Avery, L. R. (2017). Controlling images: How awareness of group stereotypes affects Black women's well-being. *Journal of Counseling Psychology, 64*, 487-499. http://dx.doi.org/10.1037/cou0000233

Kagan, P. N., Smith, M. C., & Chinn, P. L. (2014). Introduction. In P. N. Kagan, M. C. Smith, & P. L. Chinn (eds.), *Philosophies and practices of emancipatory nursing,* (pp. IX-X). New York, NY: Routledge.

Kagan, S. H., & Melendez-Torres, G. J. (2015). Ageism in nursing. *Journal of Nursing Management, 23*, 644–650. https://doi.org/10.1111/jonm.12191

Kanter, R. M. (1993). *Men and women of the corporation*. New York, NY: Basic Books.

Kearns, L. (2013). Revisiting Nurse Rivers.*Voices in Bioethics: An Online Journal of Columbia University.* Retrieved from http://voicesinbioethics.org/2013/10/14/revisiting-   nurse- rivers/

Kiegelmann, M. (2009). Making oneself vulnerable to discovery. Carol Gilligan in conversation with Mechthild Kiegelmann. *Forum: Qualitative Social Research, 10*, article 3. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1178/2718.

Kretzschmer, S., Walker, M., Myers, J., Vogt, K., Massouda, J., Gottbrath, D.,…Logsdon, M.C. (2017). Nursing empowerment, workplace environment, and job satisfaction in nurses employed in an academic health center. *Journal of Professional Development, 33,* 196-202. doi:10.1097/NND.0000000000000363

Kuokkanen, L., & Katajisto, J. (2003). Promoting or impeding empowerment? Nurses' assessments of their work environment. *Journal of Nursing Administration, 33*, 209-215. Retrieved from https://journals.lww.com/jonajournal/toc/2003/04000

Kuokkanen, L., Leino-Kilpi, H., Katajisto, J., Heponiemi, T., Sinervo, T., & Elovainio, M. (2014). Does organizational justice predict empowerment? Nurses assess their work environment. *Journal of Nursing Scholarship, 46*, 349-356. doi:10.1111/jnu.12091

Kuokkanen, L., Leino-Kilpi, H., & Katajisto, J. (2003). Nurse empowerment, job-related satisfaction, and organizational commitment. *Journal of Nursing Care Quality, 18*, 184-192. Retrieved from https://journals.lww.com/jncqjournal/toc/2003/07000

Kuokkanen, L., Leino-Kilpi, H., & Katajisto, J. (2002). Do nurses feel empowered? Nurses' assessments of their own qualities and performance with regard to nurse empowerment. *Journal of Professional Nursing, 18*, 328-335. doi:10.1053/jpnu.2002.130245

Kuokkanen, L. & Leino-Kilpi, H. (2001). The qualities of an empowered nurse and the factors involved. *Journal of Nursing Management, 9*, 273-280. doi:10.1046/j.1365-2834.2001.00253.x.

Kwate, N. O. A., & Goodman, M. S. (2014). An empirical analysis of White privilege, social   position and health. *Social Science & Medicine, 116*(0), 150-160. https://doi.org/10.1016/j.socscimed.2014.05.041

Larrabee, J. H., Janney, M. A., Ostrow, C. L., Withrow, M. L., Hobbs, G. R., & Burrant, C. (2003). Predicting registered nurse job satisfaction and intent to leave. *Journal of Nursing Administration, 33*, 271-283. Retrieved from https://journals.lww.com/jonajournal/toc/2003/05000

Laschinger, H., Finegan, J., & Shamian, J. (2001). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economic, 19*(2), 42-52. Retrieved from https://www.highbeam.com/doc/1G1-74692792.html

Laschinger, H. K., Finegan, J. E., Shamian, J., & Wilk, P. (2004). A longitudinal analysis of the   impact of workplace empowerment on work satisfaction. *Journal of Organizational Behavior, 25*, 527-545. doi:10.1002/job.256

Laschinger, H. K., Wong, C. A., & Grau, A. L. (2013). Authentic leadership, empowerment, and burnout: A comparison in new graduates and experienced nurses. *Journal of Nursing Management, 21,* 541-552. doi:10.1111/j.1365-2834.2012.01375.x

Lathrop, B., & Hodnicki, D. R. (2014). The affordable care act: Primary care and the Doctor of Nursing Practice nurse. *The Online Journal of Issues in Nursing, 19,* 2. doi:10.3912/OJIN.Vol198No02PPT02

Laveist, T. A., Isaac, L. A., & Williams, K. P. (2009). Mistrust of health care organizations   is associated with underutilization of health services. *Health Services Research, 44*, 2093-2105. doi:10.1111/j.1475-6773.2009.01017.x

Ledwith, M., & Springett, J. (2010). *Participatory practice: Community-based action for transformative change.* Portland, OR: The Policy Press.

Lewis, J. A., Mendenhall, R., Harwood, S., & Browne Huntt, M. (2013). Coping with
gendered racial microaggressions among Black women college students. *Journal
of African American Studies, 17,* 51-73. doi:10.1007/s12111-012-9219-0

Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying
intersectionality to explore the relations between gendered racism and health
among Black women. *Journal of Counseling Psychology, 64*, 475-486.
http://dx.doi.org/10.1037/cou0000231

Likupe, G., Baxter, C., Jogi, M., & Archibong, U. (2014). Managers perspectives on
promotion and professional development for Black African nurses in the UK.
Diversity and Equality in Health and Care, 11, 113-123. Retrieved from
http://diversityhealthcare.imedpub.com/archive.php

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Love, K. L. (2009). *An emancipatory study with African American at predominately
White schools of nursing.* (Unpublished doctoral dissertation). University of
Connecticut, Mansfield, CT.

Lyles, C. R., Karter, A. J., Young, B. A, Spigner, C., Grembowski, D., Schillinger, D., &
Adler, N. E. (2011). Correlates of patient-reported racial/ethnic health care
discrimination in the diabetes study of northern California (DISTANCE). *Journal
of Health Care for the Poor and Underserved, 22*, 211-25.
doi:10.1353/hpu.2011.0033

Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to
inform the future. *OJIN: The Online Journal of Issues in Nursing, 12*, Manuscript
1. doi:10.3912/OJIN.Vol12No01Man01

Matheson, L. K., & Bobay, K. (2007). Validation of oppressed group behaviors in

nursing. *Journal of Professional Nursing, 23*, 226-234.

doi:http://dx.doi.org/10.1016/j.profnurs.2007.01.007

Mathner, N., & Docet, A. (1997). Reflections on a voice centered relational method:

Analyzing maternal and domestic voices. In J. Ribbens and R. Edwards (eds.).

Feminist dilemmas in qualitative research: Public knowledge and private

lives (pp.119-147). London, UK: Sage Publications.

McCabe, J. L., & Holmes, D. (2009). Reflexivity, critical qualitative research and

emancipation: A Foucauldian perspective. *Journal of Advanced Nursing*, *65*,

1518-1526. doi:10.1111/j.1365-2648.2009.04978.x

McGibbon, E., Mulaudzi, F. M., Didham, P., Barton, S., & Sochan, A. (2014). Toward

decolonizing nursing: The colonization of nursing and strategies for increasing the

counter-narrative. *Nursing Inquiry, 2*, 179-191. doi:10.1111/nin.12042

McIntosh, P. (1988). *White privilege and male privilege: A personal account of coming*

to see   correspondences through work in women's studies. Retrieved from

http://www.iub.edu/~tchsotl/part2/McIntosh%20White%20Privilege.pdf

McNamara, S. A. (2010). Workplace violence and its effects on patient safety. *AORN*

Journal, 92, 677-682. doi:10.1016/j.aorn.2010.07.012

Meleis, A. I. (2012). *Theoretical nursing: Development and progress* (5th ed.).

Philadelphia, PA: Lippincott, Williams, & Wilkins.

Moores, P. B. (1993*). Becoming empowered: A grounded theory study of staff nurse*

empowerment. (Unpublished doctoral dissertation). University of Colorado Health

Sciences Center, Denver, CO.

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Mouton, C.P., Carter-Nolan, P.L., Makambi, K.H., Taylor, T.R., Palmer, J.R., Rosenberg,

    L., &Adams-Campbell, L.L. (2010). Impact of perceived racism on health

    screening in Black women. *Journal of Health Care for the Poor and*

    Underserved, 21, 287-300. doi:10.1353/hpu.0.0273

Munhall, P. L. (2010). A phenomenological method. In P. L. Munhall (ed.), *Nursing*

    research: A qualitative perspective (5th ed), (pp. 113-175). Sudbury, MA: Jones

    & Bartlett.

Narayan, M. C. & Scafide, K. N. (2017). Systematic review of racial/ethnic outcome

    disparities in home health care. *Journal of Transcultural Nursing, 28,*598-607.

    doi:10.1177/1043659617700710

Narayan, U. (1998). Essence of culture and a sense of history: A feminist critique of

    cultural essentialism. *Hypatia, 13*, 86-106. doi:10.1111/j.1527-

    2001.1998.tb01227.x

National Council of State Boards of Nursing [NCSBN]. (2016). 2015 National workforce

    survey. *Journal of Nursing Regulation, 7* (1 Suppl), S4-6. Retrieved from

    https://www.ncsbn.org/2015ExecutiveSummary.pdf

National League for Nursing [NLN]. (2015). Diversity and cultural competence:

    Keystone to nursing education. *The NLN Report, 25*, 3-8. Retrieved from

    http://www.nln.org/docs/default-source/nln-reports/summer15nlnreport.pdf?

    sfvrsn=2

National League for Nursing [NLN]. (2013). *About the NLN.* Retrieved from

    http://www.nln.org/aboutnln/bio_bev.htm

Ozer, E. M. & Bandura, A. (1990). Mechanisms governing empowerment effects: A self-
efficacy analysis. *Journal of Personality and Social Psychology, 58,* 472-486.
Retrieved from http://www.uky.edu/~eushe2/Bandura/Bandura1990JPSP.pdf

Oyeleye, O., Hanson, P., O'Connor, N., & Dunn, D. (2013). Relationship of workplace
incivility, stress, and burnout on nurses' turnover intentions and psychological
empowerment. *Journal of Nursing Administration, 43*, 536-542.
doi:10.1097/NNA.0b013e3182a3e8c9

Paraway, Y. (2018). *A phenomenological inquiry on barriers experienced by African
American nurses denied leadership positions.* (Unpublished doctoral dissertation).
University of Phoenix, Phoenix AZ.

Patrick, M. S. (1996). *The black stork: Eugenics and the death of "defective" babies in
American medicine and motion pictures since 1915.* New York, NY: Oxford
University Press.

Pearson, M. R., Derlega, V. J., Henson, J. M., Holmes, K.Y., Ferrer, R. A., & Harrison,
S. B. (2014). Role of neuroticism and coping strategies in psychological reactions
to a racist incident among African American university students. *Journal of Black
Psychology, 40,* 81-111. doi:10.1177/0095798412471682

Phillips, J., & Malone, B. (2014). Increasing racial/ethnic diversity in nursing to reduce
health disparities and achieve health equity. *Public Health Reports, 129* (Suppl.
2), 45-50. doi:10.1177/00333549141291S209

Phillips, J. A., & Miltner, R. (2015). Work hazards for an aging nursing workforce.
Journal of Nursing Management, 23, 803-812. doi:10.1111/jonm.12217

Pittroff, G. E. (2013). The humbled expert: An exploration of spiritual care expertise.

    Journal of Christian Nursing, 30, 164-169. doi:10.1097/CNJ.0b013e318294e8d3

Poma, P. A. (2017). Race/ethnicity concordance between patients and physicians.

    Journal of the National Medical Association,109, 6-8.

    http://dx.doi.org/10.1016/j.jnma.2016.12.002

Price, S., Doucet, S., & Hall, L. M. (2014). The historical social positioning of nursing

    and medicine: Implications for career choice, early socialization and

    interprofessional collaboration. *Journal of Interprofessional Care, 28*, 103-109.

    doi:10.3109/13561820.2013.867839

Price, S. L., & McGillis, H. L. (2014). The history of nurse imagery and the implications

    for recruitment: A discussion paper. *Journal of Advanced Nursing*, *70,*1502-1509.

    doi:10.1111/jan.12289

Puzan, E. (2003). The unbearable Whiteness of being (in nursing). *Nursing Inquiry, 10*,

    193-200. doi:10.1046/j.1440-1800.2003.00180.x

Qaabidh, L. L., Wesley, Y., Gulstone, J., & George-Jackson, G. (2011). Career

    advancement, Black nurses and healthcare disparities: Overcoming the odds.

    JOCEPS: The Journal of Chi Eta Phi Sorority, *55*(1), 2-6. Retrieved from

    http://www.worldcat.org/title/joceps-the-journal-of-chi-eta-phi-

    sorority/oclc/225100713

Rainford, W.C., Wood, S., McMullen, P., & Philipsen, N. (2014). The disruptive force of

    lateral violence in the health care setting. *The Journal for Nurse Practitioners,*

    11,157 – 164. doi:10.1016/j.nurpra.2014.10.010

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory

    for community psychology. *American Journal of Community Psychology, 15,*

    121.48. https://doi.org/10.1007/BF00919275

Read, E., & Laschinger, H. K. (2015). Correlates of new graduate nurses' experiences of

    workplace mistreatment. *Journal of Nursing Administration, 45* (Supp 10), S28-

    S35. doi:10.1097/NNA.0000000000000250

Reimer-Kirkham, S., & Anderson, J. M. (2010). The Advocate-Analyst dialectic in

    critical and postcolonial feminist research: Reconciling tensions around scientific

    integrity. *Advances in Nursing Science, 33,* 196–205.

    doi:10.1097/ANS.0b013e3181e4a7d3

Reynolds, P. P. (2004). Professional and hospital discrimination and the US Court of

    Appeals Fourth Circuit 1956-1967. *American Journal of Public Health, 94*, 710-

    720. doi:10.2105/AJPH.94.5.710

Reynolds, P. P. (2001). *Black America series: Durham's Lincoln hospital*. Charleston,

    SC: Arcadia Publishing.

Reynolds, P. P. (1997). The federal government's use of Title VI and Medicare to racially

    integrate hospitals in the United States, 1963 through 1967. *American Journal of*

    Public Health, 87, 1850-1858. doi:10.2105/AJPH.87.11.1850

Roberts, S., DeMarco, R., & Griffin, M. (2009). The effect of oppressed group

behaviours on the culture of the nursing workplace: A review of the evidence and

interventions for change. *Journal of Nursing Management*, *17*, 288-293.

doi:10.1111/j.1365-2834.2008.00959.x

Roberts, S. J. (2000). Development of a positive professional identity: Liberating oneself

from the oppressor within. *Advances in Nursing Science, 22*(4), 71-82. Retrieved

from https://journals.lww.com/advancesinnursingscience/ Abstract/2000/

06000/Development_of_a_Positive_Professional_Identity_.7.aspx

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. *Advances in*

Nursing Science, 5, 21-30. Retrieved from

http://journals.lww.com/advancesinnursingscience/toc/1983/07000

Robinson, O. V. (2013). Telling the story of role conflict among Black nurses and Black

nursing students: A literature review. *Journal of Nursing Education, 52*, 517-524.

doi:10.3928.

Rodwell, J., Brunetto, Y., Demir, D., Shacklock, K., & Farr-Wharton, R. (2014). Abusive

supervision and links to nurse intentions to quit. *Journal of Nursing Scholarship*,

46, 357-365. doi:10.1111/jnu.12089.

Rose, J., & Glass, N. J. (2010). An Australian investigation of emotional work, emotional

well-being and professional practice: An emancipatory inquiry. *Journal of*

Clinical Nursing, 19, 1405–1414, 1405. doi:10.1111/j.1365-2702.2009.02997.x

Rose, J., & Glass, N. (2008). The importance of emancipatory research to contemporary

        nursing practice. *Contemporary Nurse: A Journal for the Australian Nursing*

        Profession, 29, 8-22. Retrieved from https://pdfs.semanticscholar.org/

        2c0b/b1487f81570c69893e3dbf251e40d252676f.pdf

Ryan, C., Bergin, M., & Wells, J.S. (2017). Valuable yet vulnerable: A review of the

        challenges encountered by older nurses in the workplace. *International Journal of*

        Nursing Studies, 72, 42–52. doi:10.1016/j.ijnurstu.2017.04.006

Sasaki, S., & Vorauer, J. D. (2013). Ignoring versus exploring differences between

        groups: Effects of salient color-blindness and multiculturalism on intergroup

        attitudes and behavior. *Social and Personality Psychology Compass, 7*, 246-259.

        doi:10.1111/spc3.12021

Schroeder, C., & DiAngelo, R. (2010). Addressing Whiteness in nursing education: The

        sociopolitical climate project at the University of Washington School of Nursing.

        Advances in Nursing Science, 33, 244-255. doi:10.1097/ANS.0b013e3181eb41cf

Shahid, N. M., Nelson, T., & Cardemil, E.V. (2017). Lift every voice: Exploring the

        stressors and coping mechanisms of Black college women attending

        predominantly White institutions. *Journal of Black Psychology, 44,* 3-24.

        https://doi.org/10.1177/0095798417732415

Shahriari, N., Lakdawala, N., & Grant-Kels, J. M. (2016). Multiculturalism and diversity:

        How to ethically care for a prejudiced patient. *Journal of the American Academy*

        of Dermatology, 75, 234-236. https://doi.org/10.1016/j.jaad.2016.01.055

Shellman, J. (2004). Nobody ever asked me before: Understanding life experiences of

    African American elders. *Journal of Transcultural Nursing, 15,* 308-316.

    Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15359064

Shen, M.J., Peterson, E.B., Costas-Muniz, R., Hernandez, M.H., Jewell, S., Matsoukas,

    K., & Bylund, C. (2018). The effects of race and racial concordance on patient-

    physician communication: A systematic review of the literature. *Journal of Racial*

    and Ethnic Health Disparities, 5, 117-140. https://doi.org/10.1007/s40615-017-

    0350-4

Smith, D. B. (2015). The "golden rules" for eliminating disparities: Title VI, Medicare,

    and the implementation of the Affordable Care Act. *Health Matrix, 25* (1).

    Retrieved from https://scholarlycommons.law.case.edu/healthmatrix/vol25/iss1/4

Smith, D. B. (2005). Eliminating disparities in treatment and the struggle to end

    segregation. *The Commonwealth Fund.* Publication Number 775. Retrieved from

    http://mhrc.dopm.uab.edu/resources/Eliminating%20Disparities%20in%20

    Treatment%20and%20the%20struggle%20to%20end%20segregation%208-3-

    05.pdf

Smith, D. B. (1999). *Health care divided: Race and healing a nation.* Ann Arbor, MI:

    University of Michigan.

Sofield, L., & Salmond, S. (2003). Workplace violence: A focus on verbal abuse and

    intent   to leave the organization. *Orthopaedic Nursing*, *22*, 274-283. Retrieved

    from http://journals.lww.com/orthopaedicnursing/Abstract/2003/07000/

    Workplace_Violence__A_Focus_on_Verbal_Abuse_and.8.aspx

Sokoloff, N. J. (1992). *Black women and White women in the professions: Occupational segregation by race and gender, 1960-1980.* New York, NY: Routledge.

Sparks, A. M. (2012). Psychological empowerment and job satisfaction between baby boomer and generation X nurses. *Journal of Nursing Management, 20*, 451-460. doi:10.1111/j.1365-2834.2011.01282.x

Sparks, A. M. (2011). *Theoretical model of nurse outcomes: Associations among nurse characteristics, psychological empowerment, generation, quality of work life, and RN job satisfaction.* (Unpublished doctoral dissertation). West Virginia University, Morgantown, WV.

Spencer, S. J., Steele, C. M., & Quinn, D. M. (1999). Stereotype threat and women's math performance. *Journal of Experimental Social Psychology 35, 4–28.* Retrieved from http://nuovoeutile.it/wp-content/uploads/2013/07/Stereotype-threat-Spencer-1999.pdf

Spreitzer, G. M. (1995). Social structural characteristics of psychological empowerment. *Academy of Management Journal, 39*, 483-504. Retrieved from http://khtcam.nicico.net/Install/social%20structure/socialstruct.pdf

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology, 69,* 797-811. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7473032

Stevens, M. M., Lord, B. A., Proctor, M. T., Nagy, S., & O'Riordan, E. (2010). Research with vulnerable families caring for children with life-limiting conditions. *Qualitative Health Research, 20,* 496-505. doi:10.1177/1049732309356097

Stichler, J. F. (2013). Healthy work environments for the aging nursing workforce. *Journal of Nursing Management, 21,* 956-963. doi:10.1111/jonm.12174

Sullivan, L.W. (2013). Defining the problem: Identifying the opportunity. In P.P. Reynolds (Chair), *Conference on the history of African Americans in the medical professions.* National Academy of Sciences, Washington, D.C.

Sullivan, L. W. (2004). *Missing persons: Minorities in health professions, a report by the Sullivan commission on diversity in the healthcare workforce.* Retrieved from http://health-equity.pitt.edu/40/

Szutenbach, M. J. (2013). Bullying in nursing: Roots, rationales, and remedies. *Journal of Christian Nursing, 30,* 16-23. Retrieved from http://www.nursingcenter.com/lnc/CEArticle?an=00005217-201303000-00009&Journal_ID=642167&Issue_ID=1481430#P90

Szymanski, D. M., & Lewis, J. A. (2015). Race-related stress and racial identity as predictors of African American activism. *Journal of Black Psychology, 41,* 170-191. https://doi.org/10.1177/0095798414520707

Taylor, R. (2016). Nurses perceptions of horizontal violence. *Global Qualitative Research.* Retrieved from http://journals.sagepub.com/doi/full/10.1177/2333393616641002

Ten Hoeve, Y., Jansen, G., & Roodbol, P. (2013). The nursing profession: Public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, *70*, 295–309. doi:10.1111/jan.12177

Thomas, E., & Magelvy, J. K. (2011). Qualitative rigor or research validity in qualitative

    research. *Specialists in Pediatric Nursing*, *16*, 151-155.

    doi:10.1111/j.1744-6155.2001.00283.x

Thomas, K. W., & Velthouse, B. A. (1990). Cognitive elements of empowerment: An

    "interpretative" model of intrinsic task motivation. *The Academy of Management*

    Review,15, 666-681. Retrieved from http://www.jstor.org/stable/

    258687?seq=1#page_scan_tab_contents

Thomson, K., Outram, S., Gilligan, C., & Levett-Jones, T. (2015). Interprofessional

    experiences of recent healthcare graduates: A social psychology perspective on

    the barriers to effective communication, teamwork, and patient-centred care.

    Journal of Interprofessional Care, *29*, 634-640.

    doi:10.3109/13561820.2015.1040873

Tinsley, C., & France, N. (2004). The trajectory of the registered nurse's exodus from the

    profession: A phenomenological study of the lived experience of oppression.

    International Journal for Human Caring, 8, 8-12. Retrieved from

    https://web.b.ebscohost.com/abstract?direct=true&profile=ehost&scope=site&aut

    htype=crawler&jrnl=10915710&AN=13986022&h=2avp1%2fy8AZyVyuEE%2b

    0a93QDrcRVyzckLOfzDZEjvno6hBSfLahnqa3yotLEmsyBYHZNXpevIK%2bF

    DvWTErFv%2fsQ%3d%3d&crl=c&resultNs=AdminWebAuth&resultLocal=Err

    CrlNotAuth&crlhashurl=login.aspx%3fdirect%3dtrue%26profile%3dehost%26sc

    ope%3dsite%26authtype%3dcrawler%26jrnl%3d10915710%26AN%3d13986022

Trawalter, S. T., Hoffman, K. M., & Waytz, A. (2012). Racial bias in perceptions of

    others' pain.   *PLos One, 7,* e48546. doi:10.1371/journal.pone.0048546

Tuazon, N. C. (2010). Community outreach: Moving beyond hospital walls. *Nursing Management, 41*, 32-36. doi:10.1097/01.NUMA.0000372031.44982.99

Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*, 80-96. doi:10.1177/1473325010368316

Turner, S. G., & Maschi, T. M. (2015). Feminist and empowerment theory and social work practice. *Journal of Social Work Practice, 29,* 151-162. doi:10.1080/02650533.2014.941282

United States Agency on Aging. (2013). *A profile of older Americans: 2013.* Retrieved from http://www.aoa.gov/Aging_Statistics/Profile/2013/docs/2013_Profile.pdf

United States Department of Commerce. Department of Census Bureau. (2017). *Health insurance coverage in the United States: 2016.* Retrieved from https://www.census.gov/library/publications/2017/demo/p60-260.html

United States Department of Commerce. Department of Census Bureau. (2013*). U.S. Census bureau projections show a slower growing, older, more diverse nation a half century from now.* Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb12-243.html

United States Department of Health and Human Services. Office of Minority Health. (n.d.). *The National CLAS Standards.* Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

United States Equal Employment Opportunity Commission [EEOC]. (n.d.). *Significant EEOC race/ color cases.* Retrieved from http://www1.eeoc.gov//eeoc/initiatives/ e-race/caselist.cfm?renderforprint=1

VanderWielen, L.M., Vanderbilt, A.A., Crossman, S.H., Mayer, S.D., Enurah, A.S., Gordon, S.S., & Bradner, M.K. (2015). Health disparities and underserved populations: A potential solution, medical school partnerships with free clinics to improve curriculum. *Medical Education Online*, *20*. doi:10.3402/meo.v20.27535

Wagstaff, M. F., del Carmen Triana, M., Kim, S., & Al-Riyami, S. (2015). Responses to discrimination: Relationships between social support seeking, core self-evaluations, and withdrawal behaviors. *Human Resources Management, 54,* 673-687. doi:10.1002/hrm.21634

Wall, S. (2010). Critical perspectives in the study of nursing work. *Journal of Health Organizations and Management, 24*, 145-156. doi:10.1108/14777261011047327

Wang, X., Kunaviktikul, W., & Wichaikhum, O. (2013). Work empowerment and burnout among registered nurses in two tertiary general hospitals. *Journal of Clinical Nursing, 22*, 2896-2903. doi:10.1111/jocn.12083

Wargo-Sugleris, M., Wendie, R., Lane, C. J., & Phillips, L. R. (2017). Job satisfaction,

    work environment and successful ageing: Determinants of delaying retirement

    among acute care nurses. *Journal of Advanced Nursing, 74*, 900-913.

    doi:10.1111/jan.13504

Washington, H. A. (2008). *Medical apartheid: The dark history of medical*

    experimentation on Black Americans from colonial times to the present. New

    York, NY: First Anchor Books.

Watson, N., & Hunter, C. D. (2015). Anxiety and depression among African American

    women: The costs of strength and negative attitudes toward psychological help-

    seeking. *Cultural Diversity and Ethnic Minority Psychology*, *21*, 604-612.

    http://dx.doi.org/10.1037/cdp0000015

Webb, C. (1993). Feminist research: Definitions, methodology, methods and evaluation.

    Journal of Advanced Nursing, 18, 416-423. doi:10.1046/j.1365-

    2648.1993.18030416.x

Wesley, Y., Turner, S., & Qaabidh, L. (2011). Leadership and healthcare disparities.

    Nursing Management, 42(8), 40-45.

    doi:10.1097/01.NUMA.0000399675.97686.aa

Wicker, E. B. (1994). *Factors that have influenced the career development and career*

    achievement of graduates of Lincoln Hospital School of Nursing. (Unpublished

    doctoral dissertation). North Carolina State University, Raleigh, NC.

Williamson, K. M. (2007). Home health care nurses' perceptions of empowerment.

    Journal of Community Health Nursing, 24, 133-153.

    doi:10.1080/07370010701429512

Williamson, K. M. (2005). *Home health care nurses' perceptions of empowerment*. (Unpublished doctoral dissertation). University of Delaware, Newark, DE.

Wilson, D. W. (2007). From their own voices: The lived experience of African American registered nurses. *Journal of Transcultural Nursing, 18,* 142-149. doi:10.1177/1043659606298611

Wilson, D. W. (2003). Conceptualizing African American registered nurses as a vulnerable population. *The Journal of Multicultural Nursing and Health, 9*(1) 61-67.

Wilson, D. *(2002). From their own voice: The lived experience of African American registered nurses.* (Unpublished doctoral dissertation). Louisiana State University Health Science Center, New Orleans, LA.

Wing, S. D., Lin, A. I., Torino, G. C., Capodilup, C. M., & Rivera, D. P. (2009). Racial microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15,* 183-190. doi:10.1037/a0014191

Wong, C. A. & Laschinger, H. K. (2013). Authentic leadership, performance, and job satisfaction: The mediating role of empowerment. *Journal of Advanced Nursing, 69,* 947-959. doi:10.1111/j.1365-2648.2012.06089.x

Zurmehly, J., Martin, P. A., & Fitzpatrick, J. J. (2009). Registered nurse empowerment and intent to leave current position and/or profession. *Journal of Nursing Management, 17*, 383–391. doi:10.1111/j.1365-2834.2008.00940.x