The Experience of Racial Microaggressions of Registered Nurses Working in a Children's Hospital

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Dedication

Dedicated to my girls, Kelly and Kaitlyn. Dream big!

Acknowledgments

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Abstract of the Dissertation

The Experience of Racial Microaggressions of Registered Nurses
Working in a Children's Hospital

A report by the National Commission to Address Racism in Nursing found that nearly two-thirds of registered nurses (RNs) in a national survey (N = 5,623) personally experienced racism at work, and more than half felt that racism negatively impacted their professional well-being. Microaggressions were specifically chosen as a construct to be explored among nurses, since they are often unconscious verbal slights occurring daily and negatively impact nurses' physical and mental health outcomes. Though the Future of Nursing calls for increasing the diversity pipeline of RNs, nurses are frequent targets of microaggressions from both colleagues and leaders, resulting in burnout and negatively impacting well-being, as well as recruitment and retention efforts. A qualitative exploratory design was used to describe and gain a deeper understanding of the experience of racial microaggressions of RNs working in a children's hospital. Individual interviews of nurses were conducted, audio recorded, transcribed, and analyzed using thematic analysis. Three categories containing 12 themes resulted from data analysis. First, the category of experiencing racial microaggressions included themes of (1) biased first impressions, (2) "firing" the nurse, (3) questioning experience or credentials, (4) where do I belong? and (5) all jokes have a grain of truth. The second category of responding to microaggressions contained the themes (6) not being silent, (7) intentional nonconfrontation, and (8) showing or seeking support. Third, the addressing microaggressions using personal and professional strategies category included themes of (9) empowering, (10) bracketing, (11) communicating thoughtfully to build trust, and

(12) doing more to be perceived the same. Nurses regularly experience racial microaggressions from peers, leaders, and patient families. This results in impaired peer relationships and can negatively impact patient care. A priority area for academic and practice-based nursing educators must be to equip nurses and nurse leaders with the tools to recognize and respond to workplace racial microaggressions. Ensuring equity and inclusion is a mandate for the health and well-being of nursing as a profession.

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CHAPTER 1:

INTRODUCTION

Racism persists in current society and can be traced back to nursing's origins (National Commission, 2022). Racism is "a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race") that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources" (Jones, 2018, p. 231). The construct of racism also includes prejudice, discrimination, and antagonism based on beliefs of race superiority and can be displayed both overtly and in subtle ways (Sotto-Santiago et al., 2022). Considering racism as a systemic problem instead of an individual moral flaw and recognizing its impact on society welcomes a dialogue and process to begin dismantling unjust structures, replacing them with new systems that will foster achievement for all (Jones, 2018). It is essential to comprehend how racism manifests in society and within healthcare, including the impact of racism on health disparities and inequities (Sotto-Santiago et al., 2022).

A recently released report by the National Commission to Address Racism in Nursing found that nearly two-thirds of registered nurses (RNs) in a national survey (N = 5,623) personally experienced racism at work, while more than half felt that racism negatively impacted their professional well-being (National Commission, 2022). In addition to experiencing racism, three out of four nurses reported witnessing racism in the workplace. Of those observing racism, 57% addressed racism at work, yet 64% of nurses

who confronted racism believed their efforts did not produce change (National Commission, 2022).

Although overt bigotry and discrimination still exist, racism can often be displayed through subtle comments, looks, or tones that can be challenging to recognize (Sue et al., 2007). Termed "microaggressions," these behaviors can negatively impact people of color, simply defined as non-White people (Torino et al., 2019), and perpetuate inequities. One form of racism that nurses of color experience is demonstrated covertly "through microaggressions in the form of insults, slights, and presumptions of lack of competence and ability that have resulted in barriers hindering progression within the profession" (National Commission, 2022, p. 98). Further, patient safety and nurse well-being and job performance can suffer in the face of racism against nurses (National Commission, 2022). Sue and colleagues (2007) asserted the need to enhance societal awareness about microaggressions and their impact and implement strategies to reduce them.

The role of microaggressions has been minimized in deep-seated behaviors, both implied and overt, and associated health disparities (Ehie et al., 2021). Recipients of racial microaggressions must deal with negative feelings and decide the meaning of the insult and how to react, recognizing that responding with anger is likely to worsen the situation and further confirm stereotypes (Sue et al., 2007). Coping with ongoing exposure to racial microaggressions creates a cognitive load (Ackerman-Barger & Jacobs, 2020) which can impact intellectual functioning, including learning (Sweller, 1988).

Facing microaggressions and other forms of discrimination from colleagues and patients takes a toll on clinicians' mental and physical health. Racial battle fatigue results from the cumulative impact of facing microaggressions daily; this then creates imposter syndrome or phenomenon, which occurs when persons of color doubt their ability, as they may be the only person of their race, gender, or other underrepresented group so they feel phony when comparing themselves to others in the same role (Martin, 2019). Imposter syndrome can lead clinicians to feel isolated and inadequate because of repeated discrimination; it also impedes career progression and workplace contributions (Acholonu & Oyeku, 2020). Additionally, those from underrepresented groups can experience what is called the "minority tax," where unbalanced obligations are given to them, often without recognition or compensation. This can cause fatigue (Acholonu & Oyeku, 2020).

Moreover, there is a substantial financial cost related to burnout and turnover when nurses leave unhealthy work environments. The 2020 NSI National Health Care Retention and RN Staffing Report noted that RN turnover exceeded turnover of other hospital employees for the first time since the survey's existence, with RN turnover rising by 8.4% to 27.1% (NSI Nursing Solutions, 2021). Participating hospitals reported the average cost of bedside RN turnover costing $52,350, resulting in losses of $6.5 to $10.5 million for these hospitals (NSI Nursing Solutions, 2022). At the organizational level, the frequency of microaggressions experienced by staff can be an indicator of "the presence or even prevalence of racism in that institution" (Torino et al., 2019, p. 38). An inclusive healthcare environment can only be achieved once microaggressions, bias, and discrimination have been overcome (Acholonu & Oyeku, 2020).

Scant research exists, however, on addressing microaggressions in the nursing profession to guide interventions that will achieve a healthy work environment. Therefore, this study aimed to contribute to the evidentiary base by employing qualitative methods to describe the experience of racial microaggressions of RNs working in an academic children's hospital in the Mid-Atlantic region of the United States.

Nursing Demographics in the United States

Racial microaggressions have been linked to increased burnout and decreased job satisfaction and demand considerable emotional reserves to overcome them (Washington, 2022). As the nursing profession continues to be challenged by matching the diversity of nurses with the diverse population in the United States, losing valuable members of the profession because of racial microaggressions is tragic. Of the nearly 5 million RNs in the nation, most are White/Caucasian (81%), while Asian nurses comprise 7.2%, Black/African American nurses 6.2%, and Hispanic/Latinx nurses 5.6% of the workforce (Smiley et al., 2021). Foreign-born nurses comprise 16% of RN positions nationally, with higher numbers in some states (e.g., 29% in the District of Columbia) (Batalova, 2023). Although the proportion of diverse nurses has increased since the last National Nursing Workforce Survey, it is not growing nearly as rapidly as the diversity within the overall U.S. population. Data from the 2020 Census show that despite being the largest racial group in the country, the proportion of people identifying as White alone decreased by 8.6% in the past 10 years, to 61.6% of the population. Conversely, the multiracial population increased by 276% from 2010 to 2020, from 9 million to 33.8 million people (Jones et al., 2021). The Hispanic population group accounted for more than half of the

overall U.S. population group, increasing from 16.3% to 18.7% of the country's population over 10 years.

Changes in the census survey questions allowed respondents to answer separate questions for race and ethnicity, which may have resulted in a more accurate representation of the population's diversity. Thus, the population of Black or African American alone increased by 5.6%, while there was an 88.7% increase in those identifying as Black or African American in combination, representing 14.2% of the population (Jones et al., 2021). Greater racial diversity has been achieved with younger nurses entering the profession (Smiley et al., 2021); still, the distribution of nurses in the United States does not represent its diverse population (Noone et al., 2020; Smiley et al., 2021). Expanding nursing workforce diversity is a crucial strategy to overcome health inequities (Noone et al., 2020). Further, an absence of diversity among healthcare professionals has been associated with a negative impact on patient care, access, and patient experience in addition to job satisfaction and retention (Rotenstein et al., 2021).

Racial Microaggressions

Microaggressions were specifically chosen as a construct to explore among nurses, since they are often unconscious verbal slights occurring daily and negatively impact nurses' physical and mental health outcomes. Though the Future of Nursing calls for increasing the diversity pipeline of RNs (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021), nurses are frequent targets of microaggressions from both colleagues and leaders, resulting in burnout, negatively impacting well-being, as well as thwarting recruitment and retention efforts (Ehie et al., 2021).

The term *microaggression* was first defined by psychiatrist Chester Pierce as "subtle, stunning, often automatic, and non-verbal exchanges which are 'put downs'" (Pierce et al., 1978, p. 66). It was later characterized as "subtle insults (e.g., verbal, non-verbal, and/or visual) directed toward people of color, often automatically or unconsciously" (Solorzano et al., 2000). Later, Sue et al. (2007, p. 271) stated that "racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults" directed at underrepresented groups, such as people of color and women. *Micro* in the term *microaggression* refers to the often unconscious and subtle nature of comments, looks, or gestures, which makes them difficult to identify and address (Sue et al., 2007), rather than to their impact on the recipient.

Table 1.1

Forms of Microaggressions

Form	Definition
Microassaults	Overt conscious racism; racial slur
Microinsults	Subtle snub that can be rude, demeaning, and insensitive; intended to convey a hidden message
Microinvalidations	Interactions that discount or undermine the feelings or experience of people of color

Note: From Sue et al. (2007).

Microaggressions can be classified as three forms (see Table 1.1) and range from nine (Sue et al., 2007) to 16 categories (see Table 1.2) (Williams et al., 2021). The classifications include microassaults, microinsults, and microinvalidations, with microassaults including comments that are overt, conscious, and typically considered racial slurs (e.g., calling someone "Oriental" or displaying a confederate flag).

Table 1.2

Categories of Microaggressions

Category	Microaggression	Message
Ascription of intelligence—assigning intelligence based on race	Assuming Asian people are good at math	All Asians are intelligent and excel in math.
Second-class citizen	Black nurses are assumed to be environmental services workers	People of color do not occupy professional positions
Pathologizing cultural background and/or communication styles	Asking a Black person, "Why are you so loud?"	Adjust to dominant culture
Assumption of criminality	Store employee following around people of color	You are going to steal
Alien in own land	"Where are you from?" "Where were you born?"	You cannot be American (based on race, name, etc.)
Color blindness	"I don't see color."	Negating racial experience
Denial of individual racism	"I have Asian friends"	I cannot be racist because I have friends of different racial groups
Promoting the myth of meritocracy	"The most qualified person should be hired"	People of color receive unfair benefits due to their race
Environmental macro-level aggressions	Movies only represent White people	You don't exist/matter
Reverse-racism hostility	"You were only hired because of affirmative action"	You get unfair benefits because of your race
Tokenism	Commenting to only Black employee	Included for the illusion of inclusivity
Connecting via stereotypes	Asking Asian American friend what kind of Vietnamese food to order	Attempt to connect via a stereotype
Exoticization and eroticization	Asking Black women questions about their hair or touching their hair	You're different and not like us
Avoidance and distancing	Avoid touching people of color	There's something wrong with you
Environmental exclusion	Banning books from schools that address racism	This isn't important and didn't happen
Environmental attacks	Celebrating Columbus Day, confederate flags	Direct insult to culture or heritage

Note. From Sue et al. (2007) and Williams et al. (2021).

Microassaults are egregious and intentional and largely committed within small settings or individual interactions, whereas microinsults and microinvalidations may be committed inadvertently or unconsciously (Sue et al., 2007). Microinsults are understated comments that offend the recipient (e.g., commenting to a student of color that they performed so well on an exam). Microinvalidations occur when the experience or feelings of a person of color are negated (e.g., being asked where they are from or complimented for speaking English well) (Sue et al., 2007). The implication of these questions when asked repeatedly invalidates an individual's U.S. birthright and leads to repeated feelings of being a foreigner.

The categories of racial microaggressions include ascription of intelligence, second-class citizen, pathologizing cultural background and/or communication styles, assumption of criminality (microinsults), alien in own land, color blindness, denial of individual racism, promoting the myth of meritocracy (microinvalidations), and environmental macro-level aggressions (microassaults) (Sue et al., 2007) . In a recent review of studies on microaggression taxonomies (N = 32), Williams et al. (2021) sought to expand and enhance earlier definitions and identified seven additional categories. These added categories were reverse-racism hostility, tokenism, connecting via stereotypes, exoticization and eroticization, avoidance and distancing, environmental exclusion, and environmental attacks (Williams et al., 2021). Given the continued development and refinement of constructs related to microaggressions, a unifying model to study the phenomenon was needed. The Microaggressions Triangle Model is a simple yet eloquent representation of complex human interactions.

Microaggressions Triangle Model

The conceptual framework for the study is the Microaggressions Triangle Model (Figure 1.1), which was created in response to a request by underrepresented nursing and medical students for a tool to guide their response to a microaggression (Ackerman-Barger & Jacobs, 2020). The model is depicted as a triangle with each point representing a human perspective: that of bystander, recipient, and source of a microaggression. Within each perspective, Ackerman-Barger and Jacobs recommended an acronym guiding a genuine response.

Figure 1.1

Microaggressions Triangle Model

Many factors contribute to whether individuals can recognize and respond to racial microaggressions. If they do recognize them, there are still many reasons why nurses may not address them. Some considerations are fear of confrontation or retribution, not wanting to embarrass a colleague, power differentials, and timing. This study applied a qualitative exploratory design to describe RNs' experiences with racial microaggressions in the perspective of bystander, recipient, and source of a racial

microaggression along with how they felt and how they responded. The three perspectives and suggested responses are discussed in detail in Chapter 3.

Definition of Terms

The study terms are defined to clarify any misunderstandings, as many of these terms are related. Some of the terms are used interchangeably, which may not make them precise. The relevant terms are listed alphabetically.

Bullying is repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress in the recipient (American Nurses Association, n.d.).

Incivility is one or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them (American Nurses Association, n.d.).

Inclusion is the process by which students view themselves as active members of a larger community; where their background, insights, and contributions are valued as part of the creativity and productivity of the group (Ackerman-Barger et al., 2016, p. 1243).

Intersectionality is the interaction of social identities that contribute to multiple systems of disadvantage; for example, understanding how Christian supremacy, patriarchy, capitalism, and other systems of injustice conspire to create and maintain racism (Haeny et al., 2021, p. 888).

Microaggressions are brief and commonplace verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group (Sue et al., 2007, p. 271).

Racial discrimination is differential treatment of a person or group of people based on prejudices of their presumed racial group (Haeny et al., 2021, p. 887).

Racism is system of beliefs, practices, and policies that operate to advantage those at the top of the racial hierarchy (Haeny et al., 2021, p. 886).

Significance of the Study

Contribution to Nursing Knowledge

There is a paucity of research on nurses' experiences with racial microaggressions in the workplace. While many studies have been conducted with nursing students, medical students, and physicians regarding their experiences with microaggressions, a lack of studies exists on RNs. Of the few published, none have specifically focused on nurses working in a children's hospital, yet hospitals remain the chief practice setting for most nurses (57.5%) (Smiley et al., 2023). Among the top reasons for RN resignation were personal reasons, career advancement, relocation, salary, scheduling, unknown, education, commute, and workload/staffing ratios (NSI Nursing Solutions, 2022). It is unknown what role, if any, microaggressions may play in working conditions. Nurse educators and leaders need to understand the race-based experience of nurses in the workplace that may lead to intent to leave (Thomas-Hawkins et al., 2022) and to implement strategies aimed at retention. With over one-quarter of nurses planning to leave the profession or retire within the next 5 years, identifying and addressing causes associated with this exodus is essential for our profession (Smiley et al., 2023).

The qualitative nature of this study was exploratory and sought to achieve an understanding of nurses' experiences of racial microaggressions in a diverse workplace

that would contribute to the gap identified in the literature. This may offer some perspective on experiences of nurses as recipients, bystanders, and sources of racial microaggressions, which is not well understood.

Contribution to Nursing Practice

A deeper understanding of RNs' experiences with racial microaggressions in the workplace can identify strategies to improve nursing and organizational culture, inform future educational initiatives, and reduce nursing burnout, intent to leave, and turnover. Nurse turnover persists despite evidence on nurse intention to leave (Thomas-Hawkins et al., 2022). As the largest portion of the workforce, nurses and nurse leaders must understand how racial microaggressions affect nurse job satisfaction and patient care. This is critical given the nursing shortage and with large numbers of nurses leaving the profession. Among the factors for the nursing shortage is violence, including verbal abuse (Haddad et al., 2022). "The decade ahead will demand a stronger, more diversified nursing workforce that is prepared to provide care; promote health and well-being among nurses, individuals, and communities; and address the systemic inequities that have fueled wide and persistent health disparities" (NASEM, 2021, Summary). Health professions programs must create an inclusive environment where students and faculty can succeed and educate students and faculty on how to respond to microaggressions when they occur (Ackerman-Barger & Jacobs, 2020). Similarly, healthcare organizations must develop educational programs to enhance clinician recognition and response to microaggressions as well as to create formal reporting and supportive structures to create an equitable and inclusive environment for nurses and other employees.

Facing workplace racial microaggressions can negatively impact nurses' health and well-being. Individuals experience a significant cognitive load in processing racial microaggressions when they occur. According to Sue et al. (2007), the recipient must first decide whether a microaggression happened and then whether or how to respond. Nurses noted they "pick their battles" about when to respond to experienced or witnessed bias (Wolf et al., 2023). While not responding is an option, it has the potential to cause psychological harm, such as anger and frustration that can take a psychological and physical toll (Sue et al., 2007). Conversely, an angry reply may perpetuate stereotypes (e.g., angry Black female) that can be frustrating to people of color. Emergency nurses reported experiencing bias at work, which included retraumatization and daily harm at having to defend their credentials with both patients and leaders (Wolf et al., 2023).

Additionally, the cumulative effect of racial microaggressions on people of color is thought to increase allostatic load, which "refers to the cumulative burden of chronic stress and life events" (Guidi et al., 2021, p. 11) and can be measured by biomarkers and other clinical conditions. Physiologically, the prolonged overactivation of stress response elicited by racial microaggressions and other forms of discrimination is associated with poorer health outcomes (Jadotte et al., 2022) in people of color. Further, racism is considered a social determinant of health and is associated with poorer physical and mental health outcomes in people of color despite income and education (Jadotte et al., 2022).

Nurses and other healthcare professionals may commit microaggressions and other types of bias against patients and their families. For example, emergency nurses witnessed bias against patients as staff made judgmental comments about patients behind

their back, noted a lack of sensitivity toward LGBTQIA+ patients, and avoiding non–English-speaking families due to the increased time needed to use interpreters (Wolf et al., 2023). Upon being the recipient of racial microaggressions, it is possible that nurses and other healthcare professionals may unintentionally mistreat patients and their families.

Potential Impact on Health and Quality of Life

As the most trusted professionals and the largest workforce in many hospitals and healthcare organizations, nurses should not accept mistreatment by their colleagues and leaders. Considering the well-known negative physical and mental health outcomes experienced by the recipients of racial microaggressions and the high rates of nurse burnout, intent to leave, and turnover amidst a nursing shortage, the identification and implementation of organizational structures and educational and support strategies may lead to enhanced nurse job satisfaction and improved retention. By interviewing nurses, this study contributed to the nursing profession by communicating the experience of nurses with racial microaggressions as well as strategies suggested by the participants to support nurses. These could include training to recognize microaggressions aimed at increasing awareness, providing scripting to respond to microaggressions, and developing organizational policies to support employees from discrimination in the workplace.

Social Significance

Patients need nurses who look like them because racial discordance, when patients and providers are of differing races, leads to poorer health outcomes (Shen et al., 2018). Thus, the profession of nursing must be concerned with the diversity of nurses in

the workforce to combat the racial inequities that exist. Non-White nurses comprise 28% of nurses in the United States (NASEM, 2021); this is incongruent with the growing percentage of people of color, which comprised 40% of Americans in the 2020 census (Jones et al., 2021). Racial microaggressions have been associated with "longstanding implicit and explicit behaviors and linked to health disparities" (Ehie et al., 2021). Frequent recipients of microaggressions are women and members of underrepresented groups in healthcare (Velazquez et al., 2022). As Sue et al. (2007) suggested, efforts must be made to increase societal awareness about microaggressions and their impact and develop educational and organizational initiatives to eliminate them. Racial microaggressions faced in the workplace may impact job dissatisfaction, emotional distress, and intent to leave, suggesting that interventions to reduce racial microaggressions and improve organizational culture are necessary (Thomas-Hawkins et al., 2022).

Purpose of the Study

The purpose of this qualitative exploratory study was to describe and gain a deeper understanding of the experience of racial microaggressions of RNs working in a children's hospital.

Research Question

The study addressed one research question: What is the experience of racial microaggressions of nurses working in a children's hospital?

There were three subquestions:

1. What is the experience of racial microaggressions of nurses as a bystander?

2. What is the experience of racial microaggressions of nurses as a recipient?
3. What is the experience of racial microaggressions of nurses as the source?

Delimitations

One delimitation incorporated by the researcher in the dissertation study was interviewing hospital-based nurses, specifically those who work in a children's hospital. In the literature review, studies were limited to those involving RNs in the United States due to its historical roots with longstanding systemic racism, which may not allow for comparison with countries that do not share that history. Studies on bullying and incivility were excluded, focusing instead of studies on nurses' experiences with bias, discrimination, and racial microaggressions. Bullying and incivility are broader topics, while racial microaggressions could be a manifestation of workplace bullying or incivility but are typically subtle in their presentation. Studies on patient aggression towards nurses (e.g., from patients with psychiatric disorders) were also excluded from review. Studies on RNs only were included to make a focused comprehensive literature search for the timeframe of the dissertation.

Microaggressions can focus on an individual's race, gender, age, and/or sexual orientation, among other factors; this study focused only on racial microaggressions, which have demonstrable negative effects on recipients' physical and mental health and well-being (Spanierman et al., 2021). Moreover, racism is a national priority in the profession, with leading nursing organizations joining forces to create the National Commission to Address Racism in Nursing. The Commission has called all nurses in the nation to challenge racism at all levels to improve nurse, patient, and societal outcomes (National Commission, 2022).

Assumptions

The following assumptions were acknowledged in this study:

1. Participants in this study replied to the interview questions accurately and honestly.
2. Data collected in the interviews and resulting transcripts represented the nurses' experiences with racial microaggressions.
3. Emerging themes from the interview transcripts reflected the shared experience of racial microaggressions of RNs working in a children's hospital.

Method of Study

Using qualitative methods, particularly individual interviews with RNs, allowed for the issue of racial microaggressions to be explored and for their voices to be heard (Creswell & Poth, 2018). Specifically, a qualitative exploratory design was used to describe the attitudes and behaviors of RNs related to their experiences with racial microaggressions. This study employed a qualitative exploratory design, including some of the tenets of phenomenology espoused by Husserl to increase the credibility of the findings. These included the use of epoché or bracketing to remove researcher bias. A qualitative exploratory approach served as an appropriate lens to better allow the researcher to describe the experience from the participants' perspectives, including its meaning (Creswell & Poth, 2018). Having a better understanding of nurses' experiences with racial microaggressions in a children's hospital could inform nurse leaders and nurse educators on strategies that may foster a culture of diversity and inclusion. In addition, when nurses share barriers they face, educators and leaders can implement strategies to address or remove potential barriers (e.g., structural or process).

Theoretical Framework

The theoretical framework underpinning this study was microaggression theory, which portrays microaggressions experienced by individuals situated in the complex context of institutional and societal racism (Torino et al., 2019). This theory posits that microaggressions serve as acts to racialize people of color; that is, race is made to be their most prominent attribute. These actions or comments can be an expression of longstanding racism. Further, microaggression theory seeks to demonstrate how racism is manifested in daily interactions as racial microaggressions. While microaggressions are typically expressions of individual behavior, the attitudes and behaviors of individuals are derived from embedded culture and beliefs (Torino et al., 2019).

This theoretical framework defines the role of institutional racism in the manifestation of racial microaggressions frequently and subtly experienced today. Microaggression theory explains the relationships at institutional and societal levels that serve to perpetuate inequities and injustice to people of color (Torino et al., 2019). At the individual level, the microaggressions triangle model portrays microaggressions occurring from three different and dynamic perspectives (Ackerman-Barger & Jacobs, 2020).

Conceptual Model

The microaggressions triangle model created by Ackerman-Barger and Jacobs (2020) depicts the exchange of a microaggression from three perspectives: bystander, recipient, and source. The model resulted from a qualitative study of underrepresented nursing and medical students who expressed an interest in a structure to guide their response to microaggressions (Ackerman-Barger & Jacobs, 2020). Each of the three sides

and perspectives of the triangle corresponds to an acronym (ACTION, ARISE, and ASSIST) that helps learners respond to a microaggression from that perspective. This conceptual framework served as a foundation for this study and demonstrates the relationships between different human perspectives as the bystander, recipient, and source of a microaggression. At different times, people are capable of being in any of the three roles within the triangle.

Summary

This study contributes to the nursing and nursing education literature by expanding our understanding of the experience of nurses with racial microaggressions in the workplace, which could include interpersonal exchanges with nurses and other healthcare professionals as well as with healthcare leaders.

CHAPTER 2:

REVIEW OF LITERATURE

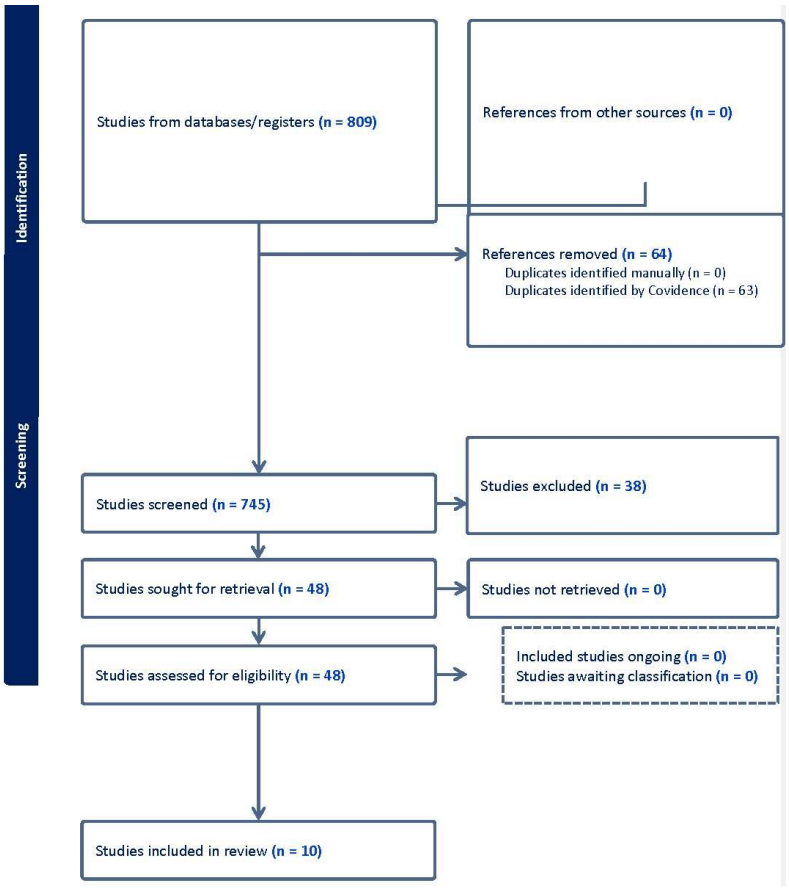
This chapter presents a review of the current literature on racial microaggressions experienced by registered nurses (RNs) in the workplace. *Racism in Nursing* noted the limited number of studies on racism in nurses and inferred findings from the psychology and sociology literature to understand the experience of Black, indigenous, and other people of color (BIPOC) nurses (National Commission, 2022). This suggests the need to conduct research to describe nurses' lived experiences with racial microaggressions, a form of racism. A diverse nursing workforce is essential to minimizing health inequities that exist due to racism. Many nursing organizations have recently called for the implementation of strategies at the university and organizational level to strengthen efforts to diversify the nursing profession (National League for Nursing [NLN], 2016; Rosseter, 2019). However, once in the workplace, nurses of color experience racial microaggressions from colleagues and leaders (National Commission, 2022). Repeated exposure to microaggressions creates a cognitive load, which negates goals of enhancing diversity, equity, and inclusion within nursing (Ackerman-Barger & Jacobs, 2020). While many studies have been conducted with nursing students, medical students, and physicians regarding their experiences with microaggressions, few studies have been conducted on racial microaggressions in practicing bedside nurses.

A comprehensive search of CINAHL and PubMed was conducted with guidance from a research librarian using the MeSH terms *nurse, nurse practitioner, education, nursing, graduate,* and *nurse clinician* for the sample. Since microaggressions is not a MeSH term, it yielded zero results when used alone in the search. Thus, the MeSH terms

were expanded to include *racism, perceived discrimination, prejudice, stereotyping,* and *unconscious psychology.* Multiple terms related to cultural competence, cultural diversity, transcultural nursing, nursing attitudes, and education were then added to account for diversity, equity, and inclusion (DEI) training. This search strategy yielded 402 and 407 results in CINAHL and PubMed, respectively, with 64 duplicates removed from the review. Of the 745 articles, 697 were deemed irrelevant via title abstract screening and 48 were further screened, with eight articles included in the final review. Two additional relevant studies were published after proposal development. Figure 2.1 shows the PRISMA diagram from the literature search.

Figure 2.1

PRISMA Diagram



Studies related to racial microaggressions specifically were included, while topics extending beyond microaggressions or bias due to gender, age, sexual orientation, or other factors were excluded. Only studies involving RNs were included. Ultimately, three quantitative studies and five qualitative studies were identified that focused on bias, discrimination, or racial microaggressions in nursing. This review of literature examines what is currently known about DEI in the workplace, nurses' experiences with racial microaggressions in the workplace, how bias and discrimination impact nurses in practice, and educational initiatives aimed at addressing microaggressions.

Diversity, Equity, and Inclusion in Nursing

A national survey of nurses in the United States concluded that racism is a problem that must be addressed in nursing, with nearly two-thirds having experienced racism in the workplace (National Commission, 2022). Several prominent nursing organizations, recognizing the problem of racism in nursing, have recently released position papers calling for a transformation in nursing education to expand the diversity pipeline accompanied by organizational support for diverse nurses once they have entered the workplace (NLN, 2016; Rosseter, 2019).

In 2016, the National League for Nursing (NLN) advocated for diversity and inclusion in nursing education and practice, understanding the inextricable link between diversity and health care quality (NLN, 2016). The organization encouraged openness in examining personal unconscious bias that may impede diversity efforts. The NLN also made recommendations for nurse leaders and deans, nursing faculty, and for itself. Recommendations for deans and directors included committing to diversity and equity, recruiting diverse faculty, evaluating outcomes of diversity efforts, and recruiting and

retaining diverse leaders. Nursing faculty were encouraged to contribute to an inclusive culture, establish academic-practice and community partnerships to expand diversity efforts, incorporate health disparities and care of diverse patients into curricula, create formal mentoring of underrepresented students and faculty, and participate in faculty development on topics such as implicit bias and microaggressions (NLN, 2016). The NLN pledged to continue its commitment to diversity and equity by supporting nursing education, collecting outcomes data on diversity metrics, pursuing funding for diversity efforts, and supplying diversity mentors for schools of nursing.

The position statement of the American Association of Colleges of Nursing (AACN) entitled *Diversity, Equity, and Inclusion in Academic Nursing* suggested the following priorities to advance DEI in academic nursing: improving the quality of education, addressing persistent health inequities, and enhancing the civic engagement potential of nursing students (Mustapha, 2021). This statement, created by AACN in 2017 with terminology revised in 2021, asserted that DEI must serve as the profession's guiding principles to achieve the priorities. Further, these values are fundamental to prepare a compassionate, respectful nursing workforce that can deliver culturally appropriate and congruent health care and reduce health inequities (Mustapha, 2021).

The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity called for ensuring diversity in the nursing workforce to reflect the racial composition of the patients and communities they serve. This report also maintained that incivility, bullying, and burnout must be addressed via organizational policies and culture to optimize nurse wellness. A chapter devoted to supporting the health and professional well-being of nurses concluded:

> Structural racism, cultural racism, and discrimination exist within nursing as in other professions. Nurses of color experience discrimination and bias within the workplace and educational systems, compounded by the lack of diversity among the nursing workforce and faculty. Nurses, educators, and health care leaders have a responsibility to address structural racism, cultural racism, and discrimination within the nursing profession across educational and practice settings, and to build structures and systems that promote inclusivity and health equity. (NASEM, 2021, p. 337)

Racism in Nursing is a recent report released by the National Commission on Racism in Nursing, which chronicled the history of racism through its present manifestations in society, nursing education, policy, practice, and research. Almost all nurses (94%) who participated in an October 2021 survey agreed that "there is some or a lot of racism in the nursing profession"; three-quarters had witnessed racism in the workplace, and 63% were recipients of racism, with Black nurses the most likely (92%) to experience racism (National Commission, 2022). This survey demonstrated that the largest proportion of racism experienced by BIPOC nurses came from colleagues followed by patients, and then administrators.

One example of racism in the workplace is the assumption that Black nurses and nurse leaders are ancillary staff or their rejection from patients who refuse their care and request another nurse. The evidence suggests that many nurses experience racism and highlights the difference in race-based experience among nurses. Therefore, it is not surprising that three-quarters of Black nurses say racism negatively impacts their well-being. Nurses experience racist acts, in equal and alarming measure, from leaders, patients, and colleagues (National Commission, 2022), though this study primarily focused on microaggressions from coworkers and leaders.

Racial Microaggressions in Nursing

Quantitative Studies

Three quantitative studies on racial microaggressions in nursing were found, and all used a cross-sectional, correlational design (Table 2.1). Moceri (2012) sought to quantify the prevalence of bias and related variables among Latino(a) nurses from a convenience sample attending a national conference (N = 111). A secondary aim of this study was to conduct validity testing for the newly developed 22-item Nursing Workplace Bias Scale, with a Cronbach's alpha of .82 established in the study. In a study of 111 nurses in various healthcare settings, 75% of nurses perceived experiencing bias at work, with one-quarter experiencing bias at least three times a week, while the majority (81.8%) witnessed bias at work, with one-third witnessing bias more than three times a week (Moceri, 2012). Within this sample, one-third of Latino(a) nurses were asked to explain cultural practices at least three times weekly, with over half of the nurses serving as a translator more than three times per week. One-third reported having a patient refuse their care due to their race. Further, results of this survey found statistically significant correlations between experiencing bias and intent to stay with the current employer (r = -.206, p = .034).

Byers et al. (2021) examined relationships between racism-related stress and psychological resilience in Black/African American RNs and advanced practice registered nurses (APRNs) (N = 77) recruited from membership of the National Black Nurses Association (NBNA). This sample of Black/African American RNs and APRNs perceived their resilience to be low in stressful situations, with a mean Brief Resilience Scale (BRS) score of 2.69 (SD = 1.67), and perceived their racism-related stress to be

Table 2.1

Quantitative Studies on Microaggressions in Nursing

Date	Author	Journal	Population	Question/Aim	Method/Design	Findings	Conceptual framework
2012	Moceri	Journal of Cultural Diversity	Latino(a) nurses recruited from national conference of Latino(a) nurses *N* = 111	To measure the prevalence of bias in the nursing workplace as experienced by Latino(a) nurses Secondary aim: conduct validity testing for the newly developed 22-item Nursing Workplace Bias Scale	• Descriptive correlational design • Survey • Nursing Workplace Bias Scale, Cronbach's alpha of .82 established in the study	• Majority of RNs in study experienced bias (73.6%), with one-quarter experiencing bias at least 3 times/ week • Most RNs witnessed bias (81.8%), with more than one-third witnessing bias at least 3 times/week • 56% of nurses were asked to translate more than three times/week	• Model of potential effects of bias, retention, and patient health and safety
2021	Byers et al.	Nursing Outlook	Black/African American RNs and APRNs Convenience sample, National Black Nurses Association membership *N* = 77	To examine the relationship between racism-related stress and psychological resilience in Black/ African American nurses	• Cross-sectional, quantitative correlational design • Instruments: - Brief Resilience Scale (BRS) - Prolonged Activation and Anticipatory Race-Related Stress Scale (PARS) • -Demographics	• Mean score for psychological resilience was 2.69, indicating perception of low resilience in stressful situations • Total PARS mean was 4.3 on scale of 1 to 7 • Significant relationship between racism-related stress and psychological variables	• Minority Stress Model

Date	Author	Journal	Population	Question/Aim	Method/Design	Findings	Conceptual framework
2022	Thomas-Hawkins et al.	Nursing Outlook	Hospital-based nurses Sample of nurses in NJ, NJ Division of Consumer Affairs website *N* = 788	To examine associations among race, workplace racism, emotional distress, job dissatisfaction, and intent to leave	• Cross-sectional, correlational design • Instruments: - Intent to leave-Y/N - Overall Job Satisfaction Scale - Well-being Index - Racial Climate Scale - Workplace Racial and Ethnic Microaggressions Scale	• 20% of nurses intended to leave job within next year • Mean emotional distress score reflected moderate distress • Most participants experienced 1-2 racial microaggressions at work in past 6 months; 28% experienced 3-6 in same period • Non-White nurses reported significantly higher levels of emotional distress, job dissatisfaction, negative racial climate, and racial microaggressions compared to White nurses	• Social Ecology of Work

high, with an overall mean Prolonged Activation and Anticipatory Race-Related Stress Scale (PARS) score of 4.3 (SD = 0.70) on a scale of 1 to 7 (Byers et al., 2021). A subscale of the PARS measured anticipatory race-related stress, which is the anticipation of racism-related stress based on prior negative incidents. This subscale had the highest mean of 5.53 (SD = 1.0), on a scale of 1 to 7, indicating increased perceived racism in this sample. Next, the Perseverance Cognition subscale had a mean of 4.34 (SD = 1.27), demonstrating a sustained negative impact of both direct and indirect racism on nurses (Byers et al., 2021). In exploring the association between the BRS and PARS total score, a significant positive correlation was noted with Secondary Appraisal ($r = .044$, $p < .01$), suggesting that perceived racism-related stress decreased with increased perceived resilience, though secondary appraisal increased with resilience.

The third study examined associations among race, workplace racism, emotional distress, job dissatisfaction, and intent to leave among hospital-based nurses in New Jersey whose names were retrieved from a public state Division of Consumer Affairs website (Thomas-Hawkins et al., 2022). Among this sample of 788 nurses, 60% were White nurses followed by 17% Black, 7-8% each for Hispanic/Latinx and Asian/Pacific Islander, 3% for multiracial, and 1.5% other. The association of workplace racism experienced by hospital-based nurses on intent to leave and the effect of racial microaggressions on intent to leave was not known (Thomas-Hawkins et al., 2022). Results from this study showed that almost one-fifth of the nurses surveyed intended to leave their job in the next year and demonstrated high stress levels, with just under half of the sample (44%) experiencing emotional distress scores of 2.0 and greater.

Most hospital-based nurses (N = 788) reported experiencing one to two racial microaggressions in the workplace in the past 6 months, while nearly one-third reported experiencing three to six microaggressions in 6 months (Thomas-Hawkins et al., 2022). In the study, Black nurses experienced the greatest number of racial microaggressions (M = 3.39) on a scale of 0 to 6 and felt the most negative racial environments (M = 58.4) on a scale of 18 to 88 compared with their peers of other racial groups. It was not specified from which racial groups RNs reported experiencing racial microaggressions. Racial microaggressions most experienced were different treatment by peers or employers followed by different treatment by patients and their families compared with people of different racial groups.

One-third of Black and multiracial nurses were most likely planning to leave their job among the surveyed nurses of color. The non-White nurses experienced significantly greater emotional distress (p = .01), job dissatisfaction (p = .001), negative racial climate (p < .001), and racial microaggressions (p < .001) compared with the White nurses (Thomas-Hawkins et al., 2022). The greatest job dissatisfaction was experienced by Black (M = 9.60) and multiracial (M = 10.6) nurses in hospitals, with Black nurses also experiencing the most negative racial culture (M = 58.4) and the most racial microaggressions in the workplace (M = 3.39). Among 788 hospital-based nurses, experiencing racial microaggressions in hospitals significantly affected nurses' job dissatisfaction (b =.62, p < .0001), leading to nurses' intent to leave their job within the next year (Thomas-Hawkins et al., 2022).

Most nurses experienced or witnessed bias (Moceri, 2012), with correlations noted between microaggressions and job dissatisfaction (Thomas-Hawkins et al., 2022)

and intent to leave (Moceri, 2012; Thomas-Hawkins et al., 2022). Further, Black/African American nurses perceived low resilience and high stress related to racism (Byers et al., 2021). The findings from these studies are concerning, despite the small sample sizes and threats to generalizability.

Instruments

The 22-item Nursing Workplace Bias Scale was completed by Latino(a) nurse attendees at a national conference (Moceri, 2012). This new instrument primarily used questions with a Likert scale, asking whether nurses had experienced bias at work followed by frequencies (e.g., daily, two to three times/week, weekly, monthly, or rarely to never). The measure also included questions on perceived support, individual competency, and intent to stay at their current workplace. The six-item Brief Resilience Scale and 17-item Prolonged Activation and Anticipatory Race-Related Stress Scale were used to collect data from March to early April 2020 (Byers et al., 2021). In contrast, Thomas-Hawkins et al. (2022) chose several measures to quantify multiple variables, using an intent to leave scale ("Do you plan to leave your job in the next year"? Yes/No), a three-item Overall Job Satisfaction Scale, a nine-item Well-Being Index, an 18-item Racial Climate Scale, and a five-item Workplace Racial and Ethnic Microaggressions Scale. Data were collected over 3 weeks in November 2020. All three studies included demographics and two issued survey reminders by email and the NBNA's Facebook page (Byers et al., 2021), whereas Thomas-Hawkins et al. sent two reminders to nonresponders.

A strength of the studies included the use of validated instruments to examine race-related variables among nurses, while Moceri (2012) sought to test validity of the

Nursing Workplace Bias Scale. Even when using multiple instruments, participant response burden was not high, with measures ranging from 22 to 36 questions along with demographic information. Studies focused on Latino(a) nurses (Moceri, 2012), Black/African American RNs and APRNs (Byers et al., 2021), and hospital-based nurses (Thomas-Hawkins et al., 2022). Small sample sizes were a limitation, and surveying one racial group of nurses did not allow for comparison of racism-related variables across nurses, whereas Thomas-Hawkins et al. (2022) demonstrated significant differences between intent to leave, racial climate, racial microaggressions, job dissatisfaction, and emotional distress in non-White nurses compared with their White peers working in the same environment. Future studies should include national surveys to allow for generalizability of results across regions and work settings that can inform evidence-based strategies to promote inclusion in nursing.

Limitations

There were several differences in the samples of these studies. One study included Latino(a) nurses attending a national conference, another recruited Black/African American RNs and APRNs across the nation who worked in multiple health care settings, and one included multiple racial groups, comparing the experiences of White nurses working in hospitals with their non-White, Black, Hispanic, and multiracial peers. Since the data collection for two of these studies occurred in March-April and November 2020, responses may have been limited due to the multiple challenges facing nurses at the onset of the COVID-19 pandemic.

Generalizability of results may be limited due to surveying nurses in one state, New Jersey (Thomas-Hawkins et al., 2022), and to the small sample size (N = 77) from

among the NBNA's 150,000 members (Byers et al., 2021). Findings may not be generalizable in the population or to all Latino(a) nurses, and since the participants were attending a conference, it is possible they may have been more interested in bias than Latino(a) nurses in the general population (Moceri, 2012). Another limitation is that 60% of the nurses surveyed about workplace racism were White (Thomas-Hawkins et al., 2022).

Qualitative Studies

Five studies were found that used varying qualitative methods to explore the experiences of nurses with bias, racism, and microaggressions (Table 2.2). Phenomenology was used to explore the lived experience of African American nurses practicing in southeast Louisiana (Wilson, 2007) and Hispanic nurses practicing in the U.S. Pacific Northwest (Wros, 2009). Wheeler et al. (2014) used a nonidentified qualitative exploratory approach to examine experiences of U.S.-educated nurses and internationally educated nurses (IENs). While the researchers considered their approaches qualitative or were published in a qualitative research journal, Cottingham et al. (2018) used audio diaries to examine the influence of race and gender on emotion practice and Moceri (2014) collected qualitative responses from a descriptive study. Although these last two studies did not use pure qualitative methods, they were included due to the lack of studies on nurses' experiences with microaggressions.

Table 2.2

Qualitative Studies on Microaggressions in Nursing

Date	Author	Journal	Population	Question/Aim	Method/ Design	Findings
2018	Cottingham et al.	Qualitative Health Research	Nurses in 2 Midwestern hospitals *N* = 48	To investigate how race and gender intersect to shape the emotion practice of nurses	Audio diaries	Select vignettes from three nurses: • Racial aggression from patients • Microaggression from patients • Microaggression from coworkers
2014	Moceri	Journal of Transcultural Nursing	Hispanic nurses, convenience sample across U.S. recruited from a national conference *N* = 111	How is bias experienced in the nurse practice environment by Hispanic nurses? To determine prevalence of bias and to create an operational definition of bias in nurse practice environment	Short written answers: Describe the bias you experienced. If a patient refused care, what was the reason given?	Three themes: • Being overlooked and undervalued (differential treatment, visibility and invisibility, negative comments) • Having to prove competency (to patients, doctors, nurses) • Living with "only-ness" (I am the only…)
2014	Wheeler et al.	Journal of Advanced Nursing	Female RNs—internationally educated (42) and U.S. educated (40) 2 urban hospitals, southeastern U.S. *N* = 82 *N*= 40 (2nd interview)	To explore experiences of nurses educated abroad and in the U.S.	• Qualitative explorative approach using structuration theory • Interviews • Purposive sampling • Sandelowski and Barroso-interpretive explanation	Four themes: • Discrimination by patients—most common; derogatory comments, questioning, assumptions, rejection/refusal of care • Discrimination by supervisory hospital personnel—bias, heavier assignments, unfair treatment, promotion/advancement; physicians

Date	Author	Journal	Population	Question/Aim	Method/ Design	Findings
					• Constant comparative method	• Discrimination by fellow nurses—African American nurse in primarily White setting, but also White nurse as minority; conflict between African American nurses and IENs • Coping: ignore, excuse behavior, confront it, change units/shifts/ leave, work harder to prove themselves
2007	Wilson	Journal of Transcultural Nursing	African American RNs, southeast Louisiana *N* = 13	To describe the lived experience of being an African American RN in southeast Louisiana	• Phenomenology • In-depth interviews followed by focus group • Snowball sampling	Two essential themes: • Connecting with the patients: holism, cultural diversity, spirituality and religion, respect and communication, caring, teaching, advocacy • Proving yourself—to colleagues, patients, themselves; credentials didn't matter; did not get promoted despite being more qualified; discrimination from both White and non-White patients; stereotypes; unfair/ unequal treatment ("dumped on") Four incidental themes: • A fulfilling dream • Being invisible and voiceless (assume any role other than nurse) • Surviving and persevering—silence, isolation, and distancing • Mentoring and role modeling

Date	Author	Journal	Population	Question/Aim	Method/ Design	Findings
2009	Wros	Journal of Cultural Diversity	Hispanic nurses in Pacific Northwest N = 27 Convenience sample Recruitment through Oregon State Board of Nursing, National Association of Hispanic Nurses-Portland chapter, word of mouth	To understand the lived experience of Hispanic nurses working in Pacific Northwest	• Heideggerian phenomenology • Interpretive phenomenology/ hermeneutics • Focus groups and individual interviews • Data analysis: thematic analysis, analysis of exemplars, search for paradigm cases	Themes: • Obligation to serve Hispanic community • Correct cultural mistakes • Teach about racism and discrimination • Protect professional relationships • Act as interpreter and cultural broker • Balance additional workload • Represent all Hispanic nurses

In exploring how race and gender impact nurses' emotion practice, Cottingham et al. (2018) sampled nurses from two Midwestern U.S. hospitals ($N = 48$) with a focus on the underrepresented groups of women of color and men in nursing. Emotion practice describes the feeling nurses experience when a discrepancy occurs between the environment and their personal values. Nurses of color faced added emotional labor, which is the need to perform above and beyond to persist and be successful in primarily White organizations, which affects the emotional resources nurses must give their patients. Nurses in this study were asked to reflect and audio record their feelings during and after their shift along with what contributed to those feelings and their response. The shift recordings were transcribed and analyzed using qualitative analysis software.

Cottingham et al. (2018) selected vignettes to illustrate the emotion practice that nurses of color may expend in relations with coworkers and patients. The vignettes included a racial aggression from two different patient types—one overt and aggressive and the other more subtle, in assuming the nurse of color was an ancillary staff member—and microaggression from a coworker. Overt racism was experienced by nurses of color as racial slurs from patients, with these encounters leading nurses to retreat from providing patient care to cope with feelings of frustration and disbelief (Cottingham et al., 2018). Microaggressions from patients could include a single question from a patient's family member that would ignite a chain reaction of emotions within nurses, along with self-doubt and reflection. Microaggressions from coworkers included feeling that coworkers talked to them differently because of their race. Because the sample in this study included both White nurses and nurses of color, the contrasting vignettes were stark in how patients responded differently to a White male nurse

compared with a Black female nurse. For example, a Black female nurse working in a psychiatric setting was exposed to verbal abuse from patients, including racial slurs, while a White male nurse working with psychiatric patients noted that patients were respectful towards him.

Moceri (2014) sought to understand how Hispanic nurses experience bias in the workplace through brief written narratives completed by 111 Hispanic nurses across the United States recruited from a national conference of Latino(a) nurses. Using content analysis of written responses, three themes were identified: being overlooked and undervalued, needing to prove competency, and living with a sense of "onlyness," with respect as a common thread across experiences (Moceri, 2014). Nurses also noted an additional burden of translating for patients and doing so without any recognition or acknowledgment of their help.

Purposive sampling was used to recruit female nurses (N = 82) from two urban hospitals in the Southeastern United States to explore experiences in the workplace of internationally educated nurses (IENs) compared with U.S.-educated nurses (Wheeler et al., 2014). As most nurses and IENS are women, only nurses who were female were eligible to participate in this study. The researchers sought to recruit a U.S. RN from the same shift and unit as an IEN in the study. Semi-structured interviews were conducted with all participants followed by a second round with half of the sample to probe deeper about emerging themes. Results of the study comparing experiences of IENs and U.S.-educated nurses yielded three themes on discrimination: experienced by patients, by hospital supervisors, and by colleagues, with a fourth theme on nurses' coping mechanisms to discrimination (Wheeler et al., 2014).

Compared to nurses educated in the United States, the IENs experienced explicit discrimination, as their accents implied their foreign status, and they were asked questions about where they were from, where they attended school, and their length of time as a nurse, suggesting that patients doubted their capabilities. Nurses also pulled from their inner confidence, with one nurse sharing that she knew she was a good nurse (Wheeler et al., 2014). Nurses in this sample felt that patients assumed things based on their skin color or accent, with even Black patients sometimes assuming a Black nurse was a technician or environmental services worker and not the charge nurse. Of all the examples given, refusing a nurse's care based on color or accent was felt to be the most prejudiced action. Types of inequity by hospital supervisors included favoritism and discrimination when seeking advancement. Both IENs and U.S.-educated nurses coped with discrimination in similar ways: "They rely on personal values to help them ignore it, they excuse the behavior, they confront it, they change units or shifts or leave their positions and/or they work harder to prove themselves to everyone around them" (Wheeler et al., 2014, p. 355).

In another study, phenomenology was used to identify the unique perspectives of African American nurses in the workplace. Semi-structured interviews and a subsequent focus group were performed with 13 African American nurses to explore their experience caring for patients, individuals, and communities in southeastern Louisiana (Wilson, 2007). Essential themes were connecting with the patient and proving yourself, and secondary themes included fulfilling a dream, being invisible and voiceless, surviving and persevering, and mentoring and role modeling (Wilson, 2007). The participants in this study shared that their credentials didn't matter; they still felt the need to prove

themselves even when they had more credentials than their peers. Further, one nurse of color shared they did not get promoted despite being more qualified than the candidate who was hired. Nurses experienced discrimination from both White and non-White patients, with examples including stereotypes, nurses of color feeling "dumped on," and unfair/unequal treatment.

Wros (2009) applied Heideggerian phenomenology to understand the lived experience of Hispanic nurses ($N = 27$) practicing in the Pacific Northwest, where there is a growing Hispanic population and small population of Hispanic RNs. The study included both individual interviews and focus groups. Data in this hermeneutic study were analyzed using a combination of thematic analysis, review of exemplars, and identification of paradigm occurrences. Finally, experiences of Hispanic nurses led to the identification of the following themes: obligation to serve the Hispanic community, correct cultural mistakes, teach about racism and discrimination, protect professional relationships, act as an interpreter and cultural broker, balance additional workload, and represent all Hispanic nurses (Wros, 2009).

Data Collection and Analysis

Data collection approaches included nurses' audio diaries, short written responses to questions, individual interviews, and focus groups. Nurses were asked to create audio recordings (diaries) following six consecutive shifts and to reflect on feelings during and after their shift, what precipitated those feelings, and their response to that emotion (Cottingham et al., 2018). The recordings were then transcribed and analyzed using a qualitative analysis software using an abductive approach, which combines inductive and

deductive coding. The researchers identified codes and used memos to document connections between emerging codes.

Moceri (2014) transcribed written responses to an open-ended question, and then analyzed the data using content analysis. The process included inductive coding followed by identification of codes, which were then collapsed into categories.

Wheeler et al. (2014) conducted two rounds of interviews: a first round to explore experiences of U.S.-educated nurses and IENs in the workplace (N = 82) and a second round to explore more deeply issues that arose in the first interviews (N = 41). Interviews were recorded, transcribed, and verified by one of the researchers. The constant comparative method was used, in which new emerging codes were compared with existing knowledge from the initial set of interviews. Other strategies to enhance validity in this study included using open and axial coding, member checking, and peer debriefing with a content expert to verify results for credibility.

Wilson (2007) conducted individual interviews followed by a focus group once the interview transcripts were analyzed and initial themes generated. To ensure rigor in this study, member checking, peer debriefing, verification of transcripts, bracketing, and an audit trail were used. Lastly, Wros (2009) used a combination of focus groups and individual interviews to accommodate participants' schedules. Audio recordings were transcribed in a deidentified manner to maintain anonymity. The researcher used three processes for this hermeneutic study: thematic analysis, analysis of exemplars, and identification of paradigm cases. A codebook was created with codes using participants' exact words to illustrate the experience exactly as described by the participants. Coding was performed independently by several coders with discrepancy resolved through

discussion. Peer debriefing occurred with both Hispanic and non-Hispanic nurses, which strengthened credibility of results.

The studies using audio diary and written narratives from nurses were limited in their methodology, as the researchers did not have an opportunity to probe further into the nurses' experiences. The audio diaries could have been initiated after a particularly emotional shift, introducing bias. Capturing experiences over six consecutive days may be a limitation, as there was no rationale for that criterion. Additionally, it was not mentioned whether member checking was done with the audio recordings or narratives, which would enhance credibility of the participants' experiences as interpreted by the researchers. Conversely, the studies conducted by Wheeler et al. (2014) and Wilson (2007) included focus groups following individual interviews to validate and clarify emerging themes with a subset of the sample. This form of member checking is a design feature that ensures rigor in qualitative methods, namely credibility (Nowell et al., 2017).

The work environments of the sample participants in these qualitative studies included clinical practice (Moceri, 2014; Wilson, 2007; Wros, 2009) and hospitals (Cottingham et al., 2018; Wheeler et al., 2014). All samples contained primarily RNs, although some (18.2%) of the nurses interviewed by Moceri (2014) were licensed practical nurses. Most of the studies occurred in specific locations within the United States and in hospital settings, which may have limited transferability of results across health care settings and across the country and beyond. Experiencing microaggressions from patients and coworkers were common themes (Cottingham et al., 2018; Wheeler et al., 2014), although the former included White nurses in the sample and contrasted stark experiences between Black female nurses and White male nurses with the same patient

type. Proving yourself or your competence was another commonality experienced by nurses (Moceri, 2014; Wheeler et al., 2014; Wilson, 2007) that led to nurses feeling compelled to prove their worth to patients, families, other nurses, and physicians, no matter their credentials or experience.

Mentoring and role modeling (Wilson, 2007) was like the teaching described by Wros (2009) and included being a good role model and feeling compelled to educate colleagues and patients about inappropriate racial comments. Teaching was an activity nurses found rewarding and felt helped them connect with African American patients (Wilson, 2007). The studies exploring the experiences of Hispanic nurses (Moceri, 2014; Wros, 2009) additionally described a burden felt by nurses to translate and explain cultural practices for patients beyond their assignment, doing so without any formal recognition or gratitude for their expertise.

Strengths of the qualitative studies on microaggressions in nurses included thorough description of qualitative methodology, coding, and strategies to ensure credibility of findings. For example, member checking and peer debriefing were used in several studies, with Wilson (2007) further detailing bracketing and use of an audit trail to enhance credibility and Wros (2009) describing independent coding by multiple researchers with discrepancy resolved through discussion. Peer debriefing with insiders and outsiders (Hispanic and non-Hispanic nurses) was another strategy used by Wros that strengthened data analysis. Two studies conducted individual interviews followed by focus groups to further explore emerging themes with the participants (Wheeler et al., 2014; Wilson, 2007). Wheeler et al. employed a recruiting strategy that matched U.S.-educated nurses with IENs by shift and unit. This allowed for a comparison between like

experiences as the nurses worked on the same unit and shift and, thus, with the same coworkers. A strength of the study performed by Cottingham et al. (2018) was including White nurses in the sample, although the study focused on underrepresented groups in nursing, women of color, and men. This allowed for a comparison of experiences between White nurses and nurses in underrepresented groups with the same patients.

Limitations

Two of the studies claimed to use qualitative methodology. One used nurse-recorded audio diaries (Cottingham et al., 2018) and the other included open-ended responses as part of a quantitative study (Moceri, 2014). These methods limited the researchers' ability to probe and further explore findings as they emerged. While Wheeler et al. (2014) used qualitative methods, the exact qualitative approach was not described. Across these studies, multiple racial groups were represented. Two studies explored the experience of Hispanic nurses, both in the Pacific Northwest (Wros, 2009) and from varying healthcare settings across the United States (Moceri, 2014). Transferability of these findings may be limited to Hispanic nurses working in other settings or regions of the country. Similarly, the experiences in urban hospitals may differ from those in rural or suburban settings and across regions of the United States.

Newly Published Studies on Bias and Discrimination

Two noteworthy studies were published recently and following this proposal and study design. The first was a mixed-methods design using online surveys and focus groups that aimed to explore knowledge, attitudes, beliefs, and experiences about implicit and explicit bias among emergency nurses (Wolf et al., 2023). A purposive sample of U.S. emergency nurses was recruited through the Emergency Nurses Association (ENA),

with 1140 emergency nurses completing the survey. The instruments used were the Racial and Ethnic Microaggressions Scale (REMS), a validated 45-item survey assessing experiences with the following: assumptions of inferiority, second-class citizen, assumptions of criminality, microinvalidations, exoticization/ assumptions of similarity, environmental microaggressions, and workplace and school microaggressions. The second validated measure was the Scale of Ethnocultural Empathy (SEE), which contains 31 elements rating empathy toward people of varying racial and ethnic backgrounds. Six-hour-long virtual focus groups were held with a subset of participants (N = 64) who had completed the survey.

Results of the survey demonstrated considerable differences in mean scores of items on race, such as appreciating the feeling of being the only person of a particular race among a group of people (non-White 5.05 versus White 3.06) and awareness of institutional barriers of discrimination (non-White 4.44 versus White 4.00) (Wolf et al., 2023). White nurses in this study also reported challenges understanding daily encounters with racial or ethnic bias (non-White 4.99 versus White 4.08). Focus groups generated several themes including witnessed bias, experienced bias, responses to bias, impact of bias on care, and solutions. Emergency nurses recounted witnessing bias towards peers and patients. Nurses personally experienced bias when patients requested to have a White nurse, questioned their skills and ability, and described daily maltreatment from patients and leaders. In this study, emergency nurses shared that bias may impact patient care in communicating with the patient and family and assessment frequency, with nurses wanting to avoid racist patients who made the workplace unbearable. Solutions proposed

by emergency nurses were an organizational focus on dismantling systemic racism, staff education on DEI principles, and staff accountability (Wolf et al., 2023).

The second newly published study was a qualitative study of 15 nurses from an academic medical center focused on their experience with racial, ethnic, and religious workplace discrimination (Saadi et al., 2023). Interviews explored nurses' experiences pre- during-, and post-encounter, with pre-encounter elements including career stage, previous experience, workplace norms and culture, and sociopolitical environment. Themes emerging during the encounter included source and harshness of the comment, resulting emotions, burden, and competing needs and demands (e.g., responding versus focusing on patient care activities). Lastly, nurses coped post-encounter through avoidance, maintaining professionalism, and responding to microaggressions, and discussed the impact of discrimination on the health care team (Saadi et al., 2023).

Interventions Addressing Microaggressions

Given the recent racial climate in the United States, health care educators and researchers have recognized the need to provide training specifically focused on racism, discrimination, and microaggressions. Several studies of curricula aimed at addressing microaggressions have been conducted with nursing students (Carter & McMillian-Bohler, 2021), third-year medical students (Acholonu et al., 2020), medical and dental students (Sandoval et al., 2020), medical trainees, faculty, leaders, and health care teams (Sotto-Santiago et al., 2020), and nursing and medical students, faculty, and leaders (Ackerman-Barger et al., 2021).

As schools of nursing seek to expand diversity within their programs, addressing microaggressions that may affect student learning outcomes is vital; thus, Carter and

McMillian-Bohler (2021) conducted a workshop using Theater of the Oppressed, which applied role play to portray a challenging scenario, followed by time for the observers to reflect and create alternate scripts to change the narrative. This session began with the establishment of ground rules and expectations, followed by brief didactic content and small group discussion of experienced or witnessed microaggressions, strategies to address microaggressions, and the opportunity to rewrite the narrative. Pre-post workshop evaluations demonstrated significant improvement in students' ability to recognize a microaggression ($N = 97$), from 10% pre-workshop to 100% post-workshop, and 84% of students initially reporting experiencing microaggressions, which increased to 96% post-session (Carter & McMillian-Bohler, 2021).

Acholonu et al. (2020) created a 90-minute workshop using multiple interactive strategies, involving case studies, pair and share, facilitated discussion, and debriefs, focused on the intent versus impact of microaggressions as well as responding to microaggressions. In small groups, students discussed examples of microaggressions and were asked to classify the microaggressions and discuss power dynamics. Themes of these conversations were impact of microaggressions on the recipient, observers, and patients, if present; strategies to support peers; and bearing in mind power differentials before responding to a microaggression (Acholonu et al., 2020). Students reported increased comfort navigating these sensitive conversations and indicated they would speak up when observing a microaggression. Of the 82 respondents to the post-evaluation, 98% were confident they could recognize microaggressions, 85% felt confident addressing a microaggression, and 99% felt they could confidently support a peer (Acholonu et al., 2020).

Using a case-based approach, Sandoval et al. (2020) developed a 2-hour workshop that included a didactic portion defining microaggressions followed by introduction of a framework (Stop, Talk, Roll) that was helpful to guide responses to microaggressions. Results of pre-workshop evaluations showed that over half (53%) of preclinical medical and dental students had personally experienced a microaggression and 66% had witnessed a microaggression (Sandoval et al., 2020). Barriers to responding to a microaggression in this sample were not knowing what to say and fear of retribution.

Similarly, Sotto-Santiago et al. (2020) developed a 2-hour workshop beginning with didactic content, then using an actual scenario that happened within the community with a debrief following. The second part of the session included individual reflection and opportunities to apply the OWTFD approach (Observe/Why?/Think/Feel/Desire). Pre-workshop, 46% to 54% of participants felt very or somewhat confident initiating discussions with peers or trainees about race, while 88% to 92% felt confident post-workshop (Sotto-Santiago et al., 2020). Responses of 25 written reflections indicated the following reasons for not addressing microaggressions: power dynamics, relationship, time, lack of knowledge on how to handle the issue, and tiredness (racial battle fatigue).

Lastly, a workshop intended to assist students and participants in identifying and addressing microaggressions used the microaggressions triangle model as a basis for response to case-based scenarios (Ackerman-Barger et al., 2021). Student self-efficacy scores ($N = 90$) increased from 2.7 (SD = 0.50) to 3.5 (SD = 0.56), $p < .001$, indicating higher confidence to address microaggressions. Additionally, students showed significant ($p < .001$) increased commitment to being an active bystander from pre- ($M = 3.33$, SD = 0.73) to post-workshop ($M = 3.7$, SD = 0.62) (Ackerman-Barger et al., 2021).

A strength of these described microaggressions curricula is that ground rules were agreed upon between facilitators and participants at the beginning of each session and facilitators verbally created a safe space for students and faculty to learn. This sets the expectation for learners to embrace being vulnerable and remain open-minded as they learn with and from their peers. Another strength is the inclusion of a model to guide response to microaggressions: the microaggressions triangle model (Ackerman-Barger et al., 2021), OWTFD model (Sotto-Santiago et al., 2020), and Stop, Talk, Roll (Sandoval et al., 2020). These models provide a useful script that individuals can apply when personally experiencing or witnessing a microaggression. Many of these sessions included engaging and interactive strategies—including role play, case-based discussion, and opportunities to practice responding to a microaggression with feedback from peers—that are effective with adult learners. The use of pre- and post-surveys allowed educational researchers to demonstrate learners' changes in attitudes and may capture intent to change behavior or commitment to act in the future.

Limitations of these curricula include lack of validated tools to measure learning and lack of standardization of curriculum delivery, timing, content, and learner types. Educational sessions on microaggressions lasted from 90 minutes to 2 hours, but it is unknown what the appropriate dose-response is for this type of training. It has been suggested that once and done is not effective and that this type of training needs to be repeated regularly to effect behavior change and organizational outcomes. While some of these curricula on microaggressions included pre- and post-evaluations measuring knowledge, others attempted to measure behavior change (e.g., commitment to engage as an active bystander) (Ackerman-Barger et al., 2021). Future research is needed to

quantity the effectiveness of microaggression curricula on individual, organizational, and patient outcomes.

Methodology

This study used basic qualitative inquiry to explore the experience with racial microaggressions of nurses working in a children's hospital. Qualitative methods were appropriate, as this topic is understudied in nurses and needs to be further explored and described. There is a lack of studies on microaggressions in the nursing literature with much more having been published in the social sciences, psychology, and medicine. Microaggressions in practicing nurses have not been well studied compared with medical student and physician experiences with microaggressions. Qualitative methods using individual interviews with RNs were most suitable due to the sensitive nature of this content and encouraged their reflection on microaggressions witnessed or experienced, and how nurses responded to them. This allowed for the issue of racial microaggressions faced by nurses to be explored and described.

The microaggressions triangle model guided the interviews to explore nurses' experiences from the perspectives of bystander, recipient, and source. For example, some nurses of color may be less frequently the recipient of racial microaggressions, but they may share times when they witnessed a microaggression as a bystander or were the source of a microaggression. Depending on the experiences shared, the researcher explored how RNs may have responded, and when they may have responded, as the timing can be sensitive if in a group setting and considering power differentials.

Summary

Most nurses have witnessed microaggressions in the workplace, and more than two-thirds have personally experienced microaggressions (National Commission, 2022). With the call to increase the diversity pipeline in nursing (NASEM, 2021) and the need to reduce health inequity, educational efforts and health care organizations must strive to promote inclusive environments. There has been a lack of studies on microaggressions in nursing, but there is evidence in studies conducted with other health care clinicians, including physicians and medical students, to support the efficacy of curricula aimed at addressing microaggressions. While post-workshop evaluations demonstrate immediate learning of participants, future studies must be conducted to evaluate longitudinal learning, application of content into practice and in interactions, and the impact on patient and staff outcomes. Although several studies have been conducted on nurses' experiences with bias and discrimination in the workplace, no studies were found that focused on nurses' experiences with racial microaggressions or whose sample included nurses working in a children's hospital. Thus, this study attempted to fill that gap in the literature.

CHAPTER 3:

METHODS

The purpose of this qualitative exploratory study was to describe workplace racial microaggression experiences of nurses. Thus, the following research question was posed: What is the experience of racial microaggressions of nurses working in a children's hospital? This chapter comprises seven sections: (a) design, including theoretical frameworks; (b) human rights considerations, (c) sample and setting, (d) data collection, (e) data analysis, (f) limitations, and (g) methods to ensure rigor. The chapter concludes with a summary.

Design

A qualitative exploratory approach served as an appropriate lens, allowing the researcher to explore the experience from the participants' perspectives (Creswell & Poth, 2018). Qualitative approaches aid clinicians and educational researchers in learning from others' experiences (Neubauer et al., 2019). The phenomenon of interest in this study was the experience of nurses with racial microaggressions faced in the workplace. Considering nurses are victims of microaggressions from both colleagues and leaders and considering the negative impact of microaggressions on physical and mental health (Ehie et al., 2021), it is critical to understand their experience to improve workplace experiences.

Philosophical Foundation

The philosophical assumption underpinning the study is ontology, which is concerned with the nature of reality as experienced by participants (Creswell & Poth,

2018). Reality is perceived differently depending on the individual's experiences and perspectives, which can be influenced by characteristics such as race, ethnicity, gender, sexual orientation, and years of experience. Because of these human differences, multiple realities exist, and sharing these realities and experiences with colleagues can lead to mutual understanding. The axiological assumption acknowledges the researcher's positionality as a Caucasian American woman who is a nurse, educator, mother, and wife. It is important to convey that although my lens and experiences may differ from that of the participants, I aimed to accurately interpret their stories. The epistemological orientation for the study was interpretive/constructivist, as the research focused on the context and conversation between individuals surrounding a microaggression and attempted to interpret the meaning of varying interactions (Creswell & Poth, 2018).

Social constructivism was the interpretive framework for this study, which holds that individuals assign meaning to their experiences based on interaction with others (social construction) as well as through cultural norms (Creswell & Poth, 2018). This framework allowed the researcher to interpret the experiences of others based on the lens with which they view and experience the world.

Microaggression theory was the theoretical framework underpinning the study, which asserts that "through racialization acts, meanings (and stereotypes and misrepresentations) of race and of particular racial groups are constructed in ways that perpetuate racism" (Torino et al., 2019, p. 38). Microaggressions are an expression of racism that establishes and perpetuates power gradients and can also be a result of racism as a subtle demonstration. While the taxonomy surrounding microaggressions has been revised in the past few decades, current definitions reflect the often unconscious and

subtle nature of racial microaggressions, making them difficult to recognize and address. Microaggression theory guided this study at the organizational level to suggest strategies and policies to educate and support nurses and other healthcare workers.

The conceptual framework, the microaggressions triangle model, was used to explore the experiences of diverse nurses as a bystander, recipient, and source of a racial microaggression. An understanding of nurses' experiences with racial microaggressions may inform educational initiatives aimed at recognizing and responding to microaggressions in the workplace, including factors that may hinder nurses from speaking up, like timing and power differentials.

Conceptual Model

The microaggressions triangle model (Figure 3.1) was created out of a need to address microaggressions when they occur in the context of human interactions and was the conceptual model for this study. Ackerman-Barger and Jacobs (2020) portrayed this interaction as a triangle with a microaggression occurring from three perspectives: bystander, recipient, and source.

Figure 3.1

Microaggressions Triangle Model

A bystander witnesses the event and can play an active role by speaking up in the moment. Alternatively, bystanders can be passive by remaining silent. There is an inherent risk in intervening, but many reasons to do so, such as creating an inclusive environment, holding others accountable for their words and actions, and showing support for the recipient (Ackerman-Barger & Jacobs, 2020). A recipient is the individual at whom the microaggression is directed. Initially, the recipient may face a dilemma of interpreting what just happened and how to respond. Failure to respond may allow stereotypes to continue, while speaking up has the potential to negatively impact relationships (Ackerman-Barger & Jacobs, 2020). This internal dilemma is exacerbated when power differentials are involved (e.g., a supervisor committing a microaggression against a nurse) wherein addressing the microaggression could impact one's reputation or employment status. A source is the individual responsible for committing a microaggression. As microaggressions are often unconscious remarks, the source may be unaware of their action's impact. Conversely, a well-meaning source who recognizes the microaggression can experience a range of emotions from guilt to defensiveness to anger (Ackerman-Barger & Jacobs, 2020). Through awareness and reflection, a source can be open to feedback from others and reduce the microaggressions they commit through intentionality in interactions.

Each side of the triangle corresponds with an acronym to guide a response from that perspective. The recipient can respond using ACTION: **A**sk a clarifying question, **C**ome from a place of curiosity rather than judgment, **T**ell what you observed using facts, **I**mpact exploration, **O**wn your thoughts and feelings, and **N**ext steps (Ackerman-Barger & Jacobs, 2020). The source can use ASSIST to respond: **A**cknowledge bias, **S**eek

feedback, **S**ay you are sorry, **I**mpact, not intent, and **S**ay **t**hank you. Third, a bystander can formulate a response by following ARISE: **A**wareness, **R**espond with empathy and avoiding judgment, **I**nquiry, **S**tatements starting with I, and **E**ducate and engage. Ackerman-Barger and Jacobs endorsed a humanistic restorative approach to call individuals into a conversation rather than chastising the source of a microaggression; they also suggested considering response as a learning opportunity and stressed that the model can be applied to promote inclusion. Therefore, applying this framework offers a caring, supportive method with which to acknowledge a microaggression while maintaining relationships.

The conceptual model of hierarchical microaggression in higher education settings was derived based on hierarchical microaggressions and bullying in colleges and universities in the United States (Lee, 2022). This model displays bullying towards students by faculty and those in higher positions of power and demonstrates the interaction between four structural frames (human resource, political, structural, and symbolic) on hierarchical microaggressions. While this conceptual model was considered for this study, it was not chosen due to its specific focus on hierarchical microaggressions occurring in higher education.

Conversely, the microaggressions triangle model is simplistic in its design and widely applicable to healthcare and other settings. As individuals, we are all capable of being the bystander, recipient, and source of a racial microaggression at different times. This model allowed the researcher to explore nurses' experiences in each perspective and how they felt and responded. This model also suggests inclusive ways to respond to

microaggressions and can be incorporated into mentoring programs and curricula to foster equity and inclusion at the systemic level within schools and organizations.

Using the perspectives of the microaggressions triangle model, in this qualitative study participants were asked to reflect on times when they witnessed a microaggression as a bystander or may have been the recipient or the source of a racial microaggression. In addition, the researcher asked how they felt and responded in each of those perspectives. Nurses' experiences with racial microaggressions from colleagues and leaders were explored, as well as how they handled them. Lastly, all nurses have likely attended some type of DEI or microaggressions training, either as a nurse or as a nursing student. They were asked whether they had participated in this type of training and, if so, the impact the training had on their practice and behavior. This data can inform future iterations of microaggressions or DEI training within the organization.

Human Rights/Ethical Considerations

This study was deemed exempt by the institutional review board (IRB) at Children's National Hospital and received full approval from The George Washington University (GWU) IRB. Once IRB approval was obtained, eligible participants were provided with an information sheet (see Appendix A) on the study purpose and elements intended to protect them as participants in human subjects research. Threats to confidentiality were minimized by ensuring a private location for virtual interviews and confirming with participants that the interviews were being conducted in a private setting. Participants selected a pseudonym for their transcripts to maintain confidentiality. In addition, any names in transcripts were deidentified, meaning that any names or locations (e.g., units, clinics) mentioned during the interviews were deleted before data analysis.

Confidentiality was further assured as shared experiences were analyzed for emerging themes with data presented in aggregate.

The information sheet advised participants of their role as volunteers and communicated that they could withdraw from the study at any time. Since participants were employees of the organization where the study was conducted, the interviewer assured participants that conversations during the interview would not be shared with other employees or supervisors, that job performance would not be affected by participation (or lack of participation), and that vignettes would be shared using a chosen pseudonym to maintain confidentiality. The information sheet was reviewed with participants, and verbal consent was obtained by the interviewer before the start of interviews. A signed consent form was not used, as it would link participants to the study. Interviews were scheduled using a video conferencing platform with a passcode to further protect participants.

Minimal risks to participate in this study were anticipated; however, it was possible that participants could become emotional in recounting personal experiences of racial microaggressions or witnessing racial microaggressions. Thus, participants were provided with information on how to access the organization's employee assistance program if needed. The researcher conducted all interviews and is a trained simulation facilitator who is skilled in debriefing and has facilitated DEI training. A mock interview was conducted with a nurse not in the sample population to test the interview guide, with changes made as needed before the start of the study. Two committee members observed the mock interview to provide feedback and guidance on the interviewing technique and interview guide. A committee member who participated in the mock interview reviewed

the first seven transcripts to determine whether any modifications to the interview guide were needed before further interviews were conducted. These interventions also assured the integrity and reliability of the study. Lastly, participants were asked for preferred contact information so that they could be reached for clarifications and member checking of themes explicated from the interviews.

Potential benefits of study participation included adding to the knowledge base about racial microaggressions in nursing and identifying strategies to create a culture of equity and inclusion within the organization and the nursing profession.

Selection of Participants and Setting

Sample

The target population was RNs at a freestanding, Magnet®-designated academic children's hospital in the Mid-Atlantic region of the United States. The sample was selected for convenience and due to the lack of published studies on the experience with racial microaggressions of RNs working in a children's hospital. This study sought to describe the experience of nurses with racial microaggressions, which can inform nursing and organizational efforts to create a culture of diversity and inclusion.

Inclusion/ Exclusion Criteria

To participate in the study, participants had to meet the following inclusion criteria:

- Be an RN employed within the sample facility
- Have experienced the phenomenon of interest (experienced or witnessed a racial microaggression in the workplace from colleagues or leaders)
- Be able to give informed consent

Participants were excluded from the study if they met the following exclusion criteria:

- Be an RN who has not experienced or witnessed a racial microaggression in the workplace

Sampling

Purposive sampling is a strategy to deliberately sample those who can provide insight into the research question (Creswell & Poth, 2018) and was used to recruit participants**.** Convenience sampling was employed, as the researcher works at the sample organization. Snowball sampling was also used, as participants were asked to share information about the study with their peers who may be interested in participating.

Recruitment

Every effort was made in the recruitment process to notify nurses of all backgrounds and genders that they could participate and were needed to participate to ensure their perspectives were shared. Nurses of all races were invited to participate in this study, as the nurses at the study site represent a wide range of diversity, with 54% of nurses identifying as White, 25% identifying as Black, 12% identifying as Asian, followed by 6% Hispanic nurses, 2% multiracial nurses, and 0.28% Pacific Islander and American Indian nurses in 2022. Nurses were asked to schedule the interview when they were not working or in a patient care assignment to minimize interruptions and ensure privacy was maintained.

The researcher served as the primary participant recruiter. After the study was approved by the IRB, multiple strategies were used to recruit nurses to participate in the study. First, the researcher announced the study via email to nursing leaders, sent emails

to the nursing distribution list, and recruited via word of mouth in daily interactions with nurses. Nursing leaders within the organization, including the director of nursing research, assisted in disseminating recruitment flyers or emails. Other tactics included posting flyers in common staff areas, such as team centers, staff lounges, and restrooms; asking nurse educators and other leaders to assist with recruitment; and rounding on the units to talk with eligible nurses. In addition, recruitment flyers (see Appendix B) were disseminated via email and hung in clinical areas not visible to patients. The recruitment flyer included information that findings from this study may inform future DEI training within the organization. Snowball sampling also occurred, as participants were asked to share word about this study to colleagues meeting inclusion criteria. Lastly, recruitment occurred through shared nursing leadership councils and nurse residency classes.

Enrollment

After agreeing to be part of the study, potential participants were contacted to schedule the interview at a time convenient for them. Nurses were sent an interview appointment via a preferred email address. The researcher sent the study information sheet along with an appointment with a link for the virtual interview via the participants' preferred email. The researcher knew which nurses were participating but did not have a supervisory role of any nurses in the organization.

Data Collection

Data collection occurred from June to August 2023 once IRB approval was obtained. Individual interviews were conducted with RNs who met inclusion criteria. Interviews were conducted in a private location via an electronic platform with cameras

on, as all participants agreed to that. Interviews were not video recorded but were audio recorded. Participants received the information sheet, including consent information, prior to the interview. The interviewer ensured participants reviewed the information sheet, answered any questions, and obtained verbal consent from participants prior to the start of the interview.

The interviews were conducted using a semi-structured interview guide (see Appendix C) with the researcher using probing questions to explore participants' experiences about racial microaggressions in the workplace. Probes included questions like, "Can you describe that more for me? Can you tell me more about that?" to prompt further reflection from participants on their experience. The interview guide was created using the microaggressions triangle as a model as well as modifying questions from published interview guides from studies on microaggressions in healthcare (Shang et al., 2021; personal communication, Kupiri Ackerman-Barger, March 16, 2022). It was shared with participants that the interview was anticipated to last no more than 60 minutes. Audio recordings were sent securely to a professional transcription service to be transcribed verbatim with any identifying comments deidentified to protect confidentiality. All recordings and transcripts were stored according to the George Washington University policy on data storage and privacy.

Evidence suggests that six to seven interviews are generally needed in qualitative research to reach redundancy and data saturation in a homogenous sample (Guest et al., 2020). However, this study sought a diverse sample of nurses from varying racial backgrounds. The researcher aimed for saturation, which is the point in data analysis at which more interviews do not reveal additional insight into the categories (Creswell &

Poth, 2018; Guest et al., 2020). Therefore, it was anticipated that the study sample would include 15 to 20 interviews, but interviews were conducted until saturation was achieved.

Data Analysis

The qualitative data software NVivo (release 1.7.1) was used for data analysis. This software organized data for the dissertation and allowed for multiple coders to access and code data simultaneously. To analyze data, thematic analysis was used, which allowed for exploration of data using longer phrases (Saldaña, 2021) and provided a flexible and accessible form of qualitative data analysis (Nowell et al., 2017).

Braun and Clarke's (2006) six-phase approach to thematic analysis was used. The phases are)1) familiarizing yourself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. In the first phase, the researcher becomes immersed in the data through data collection and continual reading of transcripts and begins making preliminary notes or highlighting pertinent ideas. Second, the initial notes lead to code generation once the researcher is familiar with the data. Data are analyzed at a broader level with codes combining to form themes in Phase 3. Relationships between codes and themes are also considered in this phase (Braun & Clarke, 2006). Phase 4 involves refining themes, which includes determining whether identified themes have sufficient data to remain themes and identifying two or more themes that may fold into one overarching theme. The researcher defines each theme and ensures the essence of the theme as described by participants is captured in Phase 5. Lastly, the researcher presents the data, offering ample support of each emerging theme using the exact words of the participants.

Transcripts were compared with audio recordings to ensure accuracy, with edits made as needed and names or locations deidentified prior to data analysis. After reconciliation, the researcher read each transcript fully to understand the story being shared by each participant and to gain an overall feel of their experience related to microaggressions. Second, the researcher engaged in inductive coding followed by deductive coding using the a priori codes from the microaggressions triangle model (i.e., experiences as a bystander, recipient, and source of a microaggression). Not all the pertinent information fit neatly into one of these theoretical or etic codes; thus, inductive coding identified new emic codes emerging from the transcripts (Saldaña, 2021). These keywords were the basis for the codebook, which evolved through subsequent readings of the data and discussion.

The researcher and a committee member independently coded three transcripts. The researcher created a draft code book after completing first-level coding of all 18 transcripts. Then the researcher met with the committee member to verify the codebook and discuss emerging codes. The second coder independently reviewed the remaining 15 transcripts using the codebook as a guide and conducted consensus coding with the researcher. The coders met regularly to discuss, assign meaning to the codes, define themes, and interpret the results. Discrepancies among coders were discussed with the committee member until consensus was achieved.

Memos were made throughout as a technique to capture impressions about the emerging concepts, to note connections between codes and themes, and to document decisions made by the research team on collapsing or expanding codes into themes (Bernard et al., 2017). The researcher coded independently and enlisted a colleague who

had experience with qualitative studies to also code independently. Triangulation occurred, as the two researchers independently coded transcripts, expanding the observation and interpretation of emerging themes (Carter et al., 2014). The codebook was then analyzed for patterns or words with the identification of themes that present the experience in a summarized fashion, with the quotes emphasizing the exact experience as described by the participants (Creswell & Poth, 2018).

Given the focus of this study, emotion coding was appropriate to use, as recalling experiences of microaggressions may evoke varying emotions from the participants. This type of coding is suitable when studying intrapersonal and interpersonal interactions and may also offer insight into perspectives (Saldaña, 2021). To capture the experience of the participants, using in vivo codes served as an impactful technique. This approach uses participants' own words to describe their experience (Saldaña, 2021). The researcher also considered using values coding as an approach to signify the participants' viewpoint in describing their response to microaggressions. According to Saldaña, values coding is fitting when exploring cultural standards and interpersonal and intrapersonal interactions. Emotion, in vivo, and values codes can be integrated in a way to facilitate an understanding of the conceptual framework underpinning the research. Codes and emerging themes were reviewed, and consensus was reached through discussion. Finally, themes were named and defined by the research team.

Once the themes were named and defined, a validation technique called member checking (Creswell & Poth, 2018) was conducted. All participants were contacted and asked to review the explicated themes (member checking) for congruence with their described shared experiences. Ten participants responded that the summary of themes

encompassed their experience with workplace microaggressions, with one clarification made based on feedback from one participant.

Limitations

This study was conducted at an academic, Magnet®-designated, freestanding children's hospital in an urban setting with a diverse nursing workforce. This may limit transferability of results to nonacademic organizations or other dissimilar settings, including healthcare organizations with homogeneous patient populations and staff. Variables outside of the researcher's control that could impact experiences include previous formal education about microaggressions, other DEI training sessions attended, and personal background, demographics, attitudes, and beliefs.

Methods to Assure Rigor

Multiple strategies were used to ensure rigor in this qualitative study. Several methods are recommended to evaluate the validity of qualitative findings (Creswell & Creswell, 2018). Reflexivity involves the researcher's acknowledgment of her role in the research and appreciation that her prior experiences, assumptions, and beliefs could influence the research process. Reflexivity was achieved by communicating the context between the researcher and study participants, increasing the credibility of the findings (Creswell & Poth, 2018). The researcher has worked in the study organization for decades and documented perceived biases through bracketing, which is a reflection exercise intended to suspend judgment and instead focus on the experience as shared by participants. Following completion of the first seven interviews, audio recordings were reviewed by the researcher and a committee member for interviewing technique and to

ensure that the interviews were eliciting the desired responses of nurses' experiences. A committee member agreed that the researcher's employment within the organization was not hindering participants from sharing their experiences openly.

Memos were used during data analysis to acknowledge personal bias based on previous experiences. In addition, to minimize researcher bias and remain open to interpreting the experiences from the learner's perspectives, an inductive analysis approach was used, allowing themes to emerge from the nurses' own voices. Triangulation occurred, as two researchers independently coded transcripts, expanding the observation and interpretation of emerging themes (Carter et al., 2014). Independent coding allowed for different perspectives, thus increasing confirmability of findings.

The use of in vivo quotes provided the rich, thick description that will allow readers to experience the phenomenon, and the sample and setting were clearly defined for readers to determine transferability of results to their setting. Peer debriefing between the coders and a committee member was used to check emerging codes and themes. A committee member and other mentors who are methods and content experts served as peer debriefers to the research team, which enhances validity of findings (Creswell & Creswell, 2018). Trustworthiness was established using rich, thick descriptions of the participants' experiences to convey the results, such that the reader is immersed in the experience (Creswell & Creswell), and by detailed description of the data analysis process and the methods of analysis for the reader to determine credibility.

Qualitative reliability was accomplished by verifying the accuracy of transcripts, using code definitions, and engaging in discourse to achieve intercoder agreement (Creswell & Creswell, 2018). An audit trail demonstrated support for decisions made

during data analysis and can assist other researchers in reviewing results and conclusions by following the detailed notes and memos kept by the researcher (Nowell et al., 2017). Member checking was conducted to assure credibility of results, wherein the researcher shared emerging themes with a subset of the sample to determine accuracy of the interpretation (Nowell et al., 2017).

Summary

A qualitative exploratory design was used to meet the study purpose and answer the research question. This project resulted in the description of the experience of racial microaggressions from colleagues and leaders among nurses working in a children's hospital. The protection of human subjects and ethical considerations were described. Participants were recruited using purposive, convenience, and snowball sampling. Individual interviews were conducted with nurses, audio recorded, and then transcribed. Data analysis was conducted using Braun and Clarke's (2006) approach to thematic analysis. In addition, the setting and study limitations were explained. Lastly, appropriate methods used to assure rigor for the qualitative exploratory study design were presented.

CHAPTER 4:

PRESENTATION AND ANALYSIS OF DATA

This study explored workplace racial microaggression experiences of nurses practicing in an academic children's hospital in the Mid-Atlantic region of the United States. Although the primary interest was racial microaggressions experienced from peers and leaders, study participants also shared examples when patients and families exhibited these behaviors. The study purpose was met by gaining a deeper understanding of nurses' experiences with racial microaggressions as a bystander, recipient, and source, as well as how they felt and responded during these experiences. This chapter presents the results of the research question: What is the experience of racial microaggressions of nurses working in a children's hospital? Participant demographics and individual characteristics are described followed by the themes that emerged from data analysis. Although the focus of this research study was on nurses' workplace racial microaggression experiences, participants were asked about their experiences with DEI training and organizational policies and made recommendations to improve workplace culture. Thus, the chapter concludes with implications for DEI training and organizational policies and procedures.

Sample Demographics

The sample of 18 registered nurses ranged in age from 22 to 66 years with an average of 39 years. Years of nursing experience ranged from 4 months to 42 years, and on average, nurses had 12.9 years of nursing experience and had worked in the sample organization for 11.6 years. Sixteen of the nurses identified as female and two as male. RNs identified ethnically as Black or African American, Afro-Caribbean, African, Asian

American, Asian, Latina, or White, and most were from the United States with a few other countries of origin represented. RNs worked in both inpatient, outpatient, and mixed areas. Demographic information is presented in Table 4.1. Individual interviews were conducted either virtually (N = 15) or in person (N = 3) in a private office and lasted between 19 and 60 minutes, with an average interview time of 36.5 minutes. Pseudonyms and individual participant characteristics are presented in Table 4.2.

Table 4.1

Sample Characteristics

Characteristics	N (%)
Total participants (N)	18 (100%)
Nursing experience	
Less than 5 y	4 (22%)
5-10 y	7 (39%)
11-15 y	2 (11%)
>15 y	5 (28%)
Highest education	
BSN	12 (67%)
MSN, Master's	4 (22%)
Postgraduate, doctoral degree	2 (11%)
Clinical area	
Inpatient	8 (44.4%)
Outpatient/ambulatory	6 (33.3%)
Combination (inpatient and outpatient)	4 (22.2%)
Identify racially	
Asian	1 (5.6%)
Black or African American	6 (33%)
Chinese	2 (11%)
Filipina	2 (11%)
Thai	1 (5.6%)
Vietnamese	1 (5.6%)
White	5 (28%)
Identify ethnically	
African, Afro-Caribbean	2 (11%)
Asian, Asian American, Chinese	7 39%)
Black or African American	4 (22%)
Latina	1 (5.6%)
White	4 (22%)
Country of origin	
China	1 (5.6%)
Philippines	1 (5.6%)
Thailand	1 (5.6%)
U.S.	15 (83.3%)

Table 4.2

Pseudonyms and Individual Participant Characteristics

Pseudonym	Gender	Age range	Identified ethnicity	Highest education	Years of nursing experience
Amy	F	40-49	Asian	Doctorate	15-20
Aquarius	F	40-49	Black	BSN	6-10
Brittany	F	50-59	Asian-American	BSN	>25
Chris	M	40-49	White	Master's	6-10
Eileen	F	50-59	Asian	BSN	>25
Elsbeth	F	30-39	Afro-Caribbean	Master's	<1
Hannah	F	20-29	Asian	BSN	1-5
Jen	F	40-49	Asian	BSN	11-15
Jessica	F	30-39	African	Master's	11-15
Katherine	F	30-39	White	BSN	6-10
Nicole	F	20-29	White	BSN	1-5
Palmer	F	50-59	White	BSN	>25
Rachel	F	20-29	Asian-American	Master's	<1
Sam	F	30-39	Black	BSN	6-10
Samantha	F	30-39	Black	BSN	6-10
Sarah	F	20-29	Latina	BSN	1-5
Scott	M	20-29	Asian-American	BSN	1-5
Sheila	F	60-69	Black	Postgraduate	>25

Three categories resulted from data analysis: (a) experiencing racial microaggressions, (b) responding to microaggressions, and (c) addressing microaggressions using personal and professional strategies. Within these categories, 12 themes emerged. While the microaggressions triangle model guided the study, data are organized and presented by the emerging categories and the corresponding themes (see Table 4.3). Within each theme, data are presented where the nurse was recipient, bystander, and/or source. The chapter concludes with concepts uncovered in the interviews regarding the genesis of racial slights, implications for patient care, sources of microaggressions from nurses' experiences, and the impact of workplace microaggressions on RNs.

Table 4.3

Categories and Themes Identified in Data Analysis

Categories	Themes
Experiencing racial microaggressions	1. Biased first impressions • Making comments about race • Making assumptions • Labeling or judging patients/ families based on race • Invasive questions/ comments 2. "Firing" the nurse 3. Questioning experience or credentials 4. Where do I belong? 5. All jokes have a grain of truth
Responding to microaggressions	6. Not being silent • Speaking up • Correcting an assumption/ educating 7. Intentional nonconfrontation • Using humor • Giving people a pass 8. Showing or seeking support
Addressing microaggressions using personal and professional strategies	9. Empowering • Coworker support • Family support • Leader support • Organizational support 10. Bracketing 11. Communicating thoughtfully to build trust 12. Doing more to be perceived the same

Experiencing Racial Microaggressions

Nurses in this study personally experienced microaggressions as recipient, bystander, or source, aligning with the perspectives of the microaggressions triangle model, and described these as microinvalidations, microassaults, and microinsults (Sue et al., 2007). All nurses in this study witnessed racial microaggressions in the workplace, and most nurses reported having personally received them as well as being the source of a microaggression at some point. Some nurses shared that they were careful to avoid being the source of racial microaggressions since they were aware of the hurt they

personally felt as a frequent recipient of racial microaggressions. In detailing their experiences with racial microaggressions in the workplace, some nurses claimed there was nothing "micro" about it, that at times they experienced overt racism. The five themes in the category of Experiencing Racial Microaggressions are Biased First Impressions, "Firing" the Nurse, Questioning Experience or Credentials, Where Do I Belong? and All Jokes Have a Grain of Truth.

Theme 1: Biased First Impressions

Nurses in this sample recalled racial microaggressions they had observed as bystanders made solely on appearance or name and without having met or known the individual, which indicated biased first impressions. These were most often directed toward coworkers or patients and their families from other coworkers or patient families, and ranged from subtle comments to overt racism and stereotyping. Examples included making comments about race, making assumptions, patient families refusing care of nurses based on their race, and labeling or judging coworkers or patients or their families based on race. In this sample, nurses of color were most likely to personally experience racial microaggressions from peers, leaders, and patient families. Nurses faced several types of racial microaggressions as recipients, including the mistreatment of Black nurses, perceptions of Asian nurses, and invasive questions. Largely, microaggressions focused on making assumptions or making comments about race, but as is the case with microaggressions, many of the slights were subtle in their delivery, making the nurses wonder what was meant by them. In contrast, some of the comments were overtly racist. Examples included nurses commenting that their colleagues mispronounced their name after working together for several years, which was "frustrating."

Eileen reflected,

> I guess there are instances where people treat you a certain way and you immediately kind of have your guard up. We get people in our facility from all sorts of locations in our city, and you don't want to be judgmental, but sometimes because the way they treat you and the way they speak to you, you react to that. So I think in that way, I could have been the source of it if I'm not aware of how I'm presenting myself. To get offended, I guess, is the easiest way to do that. And that doesn't help any situation of microaggression. Definitely disappointed in myself. You want to do right by everybody that comes to your facility. You want to give everyone good care. And not that you don't, but you feel like you have limitations when people are not being kind to you or they're being aggressive. And I recognize it's not the person, it's just how the society or how they're raised.

Most nurses in this sample shared a time when they unintentionally were the source of a racial microaggression and apologized, reflected, and sought to learn from the experience. A few were unable to think of an example in the moment but felt that they likely had committed a microaggression at some point. Scott shared, "I spend a ton of energy to make sure that I don't step on toes in that way." Likewise, Aquarius said, "You try your best not to try to make anybody else feel like that, if that makes any sense to you. I try my best, but we're all not perfect." Jen admitted, "I think I could be, but I cannot remember." Sam also could not recall being the source, adding, "And that's not to say that it hasn't happened, though, because that's what happens, right? You unintentionally say things."

Samantha recalled,

> I don't know that I would have said or done anything. Even behaviorally, I don't know because I've always felt like a very inclusive person. Not that I don't see color, because clearly everybody's different, but I just try to function as if everyone's an equal. I don't think I have any because my approach with people is just that I'm going to treat Person A, Person B, Person C the exact same until I feel like a behavior is different towards me or that they don't want that kind of interaction with me, if you will. So I honestly can't think of any.

Lastly, Brittany couldn't recall committing a microaggression, but noted, "I'm a friendly person. I can tolerate you even if you're so mean.… If we cannot be friends, I can still treat you professionally."

Making Comments about Race. Nurses in the sample were bystanders who overheard comments made about race to and about people of color, including patients, their families, nurses, and other coworkers.

Palmer noted conflict between African-born and African American nurses on her unit:

> So there's been some African American people or who I would say born and raised here. And then some people who are newer to this country and they are sort of judgy towards each other. Mostly the American Black folks against the newly arrived here. Acting like they aren't as smart as we are and have a different level of care. And that's been many times they'll say it, they'll say something negative and then say, "You know, she's African." Like a qualifier that tries to explain away why they're saying something negative.

Chris overheard staff members referring to patients as "immigrant babies or anchor babies to get citizenship," which was awkward and made him cringe. Additional comments made by staff, like "oh, they're acting so ghetto" or "I can't believe that this kid's hair is like this," can be perceived as judging patients based on race or socioeconomic status. He felt the need to defend patients, as these comments were not fair to the child, adding, "There are other people in ear shot which is not appropriate to hear and I don't want other families hearing it thinking that everyone thinks the same way."

A witnessed microaggression that can have a negative impact on patient care is when there is reciprocity of aggression. For example, Rachel noted patient families

> comment to the charge nurse that a certain nurse is rude or has an attitude. I feel like, time and time again, that's always Black nurses, and it's just so messed up. It's so hard because we work in a customer service-based industry. I feel like the families are being rude to the nurses because they're Black. And then the nurses are just like, "I need to assert that I'm the nurse. I know what I'm doing."

Jessica heard a nurse leader make comments about a Black nurse's social media page in which she was wearing a scrub top from the unit, "Well, I don't want her wearing that in the picture. I don't want her ... people knowing that she's representing us."

Samantha remembered a former physician leader from the South who made overtly racist comments and could barely believe these words were spoken when she heard them. One example was, "It's a black and white situation. Black, where it's completely in error, and white, where it is pristine and ready to move forward" and "The way we would handle this where I came from is an old-fashioned hanging."

Nurses shared racial microaggressions they had experienced as recipients from peers and patients or their families, which ranged from subtle to overt racism. Elsbeth had a non-American patient say to her, "and it was also maybe in jest, but 'I love when I have White nurses because I know I'm going to get good care.' But the thing is, they [parents] were Black too." The same family made other racial stereotypes of nurses' work ethic: "She was saying that the White nurses are very attentive. The Black nurses just aren't her favorite. I think she actually said Filipino nurses are lazy. She said a lot."

Amy recounted that randomly in meetings, people will make comments about her being Asian or Chinese when it has no relevance to the work. This made her uncomfortable and she didn't like it, as the subtle comments were associated with a negative Asian stereotype.

Scott experienced staff members mispronouncing his name, calling him the wrong name, and frequently forgetting his name altogether. This happened "a lot more recent than I would like it to happen," despite having worked on a unit for a few years, and he noted one coworker as the "worst aggressor" who has called him multiple incorrect names and even writing his name on the nursing patient assignment incorrectly.

Hannah shared a recent experience with a patient family in which she was "taken aback" when caring for a patient who came to the hospital for swollen eyes and his mother commented multiple times that his eyes were "chinked" and physically pulled her eyes taut. This made her feel very uncomfortable, although she did not say anything in the moment because "I don't know, I feel like I'm not one to maybe start conflict with patients."

Nurses acknowledged that sometimes microaggressions occurred, despite positive intent. Amy was approached about being featured for an employee diversity spotlight and declined to participate.

> You don't want to be given something special, like "We're going to spotlight you just because you're Chinese." This is an accident of my birth. It's not something merit based. And I think part of the culture is, nobody wants something.... It doesn't feel genuine. It feels against what you've been raised is valuable. Like hard work and achievement, not, "Hey, you were born Chinese, let's say that you're special."

A patient commented to Aquarius, "Oh, you're a nurse? Oh, I've never had a Black nurse before." She also noted the lack of diversity on the units and on the organization's social media accounts, emphasizing the importance of representation in such a diverse urban area.

Eileen shared an example in which a coworker she's known for a long time mentioned that they were going to give special consideration to people of different socioeconomic backgrounds for an achievement test:

> And she said, "Oh, my poor little White boys, they don't stand a chance." And it was just a very odd thing to say to me. My kids are biracial. And I was just, I don't know. I feel like since then, I haven't even looked at this person the same way because I thought that was a very ... I don't know. She wasn't reading the room because there were other people there with biracial children, and I'm a person of color, so it was just kind of a different interaction.

This interaction offended her and impacted her perception of that coworker. "I'm sure everyone thinks she's a nice person or whatever, but I have a different take on that."

Occasionally nurses and other clinicians were sources of microaggressions against patients, their families, or coworkers. Samantha noted the stigma on patients with sickle cell disease when coworkers would say, "Oh, they're problematic. They're drug seeking. They're just difficult to work with." In her experience, patients with sickle cell are not problematic at all, but rather in pain and miserable.

> Families are labeled these certain things just based upon race. But when I go in and talk to the family, I don't have that experience at all. Most times it's that they're saying, "Well, I tried to express this and the nurse didn't want to hear me, or the physician didn't want to hear what I had to say."

Katherine mentioned that when she's with one of her Black coworkers whom she considers a good friend, she may "take on her voice or use some of the language she may use." Reflecting on it during the interview, she stated that it made her "feel kind of silly, I feel kind of dumb. No, I probably shouldn't. I don't want to offend anybody."

> At a recent social event for hospital employees and their families, Sheila noted,
>
> I didn't see Caucasian people grabbing plates full of food, but Blacks and Asian people act like they hadn't eaten in days. Seriously. And I've made that comment like, "What the heck?" So that was kind of microaggression to sort of perceive

> that the Asians and the Blacks were greedy for the food, but I didn't see that in the Caucasian people. And I made a comment about it, and it could have been a little racial microaggression.

Palmer, intending to compliment a coworker, said,

> "I just think you look beautiful. I just think you look exotic and interesting." And she found the word *exotic* inappropriate, she thought that was racially, she did not feel comfortable with that word. And this was my friend, I felt horrible. And she didn't say, "Okay, you racist weirdo," or anything, but she said, "I don't like that word. I don't think you should use that word to at least describe me." But she then let me know that perhaps other people wouldn't find that complimentary. And I meant it complimentary because like I said, I'm just boring, white-skinned brown hair, and she's just gorgeous. She didn't like that word. And it wasn't that she didn't like the word, I think she thought it was inappropriate, culturally inappropriate. And I had to apologize and say, "I meant it as a compliment." She's like, "It's not a compliment." So yes, that would be an example that sticks with me because I said something that hurt somebody's feelings based on how they presented themselves and she didn't like that. She was schooling me, and I think she knew I meant it. She could tell I was paying her a compliment, so she was letting me know that is not a compliment.

Having had to interview candidates for highly technical positions who "were trained outside of the United States and have foreign-sounding names that I have never seen before and can't pronounce," Amy admitted,

> This one really troubles me, and I don't know how to get rid of it. It's not that I don't promote or advocate for these people or give their resumé a good look. It's just, I know that I'm less comfortable with them in interviews. I'm less comfortable with understanding their background because their training is not an East Coast school that I am familiar with, that I've been to, or that I know people who've graduated there. And it takes more work to see what kind of institution it was, to do some research. And that's troubled me, because I know that's one way that microaggressions can really hurt people is, you want to hire people that you're comfortable with, or that you identify with. And that can really hurt people who are not in one of the ethnic or racial majority backgrounds.

Making Assumptions. Nurses were bystanders of assumptions that were made based solely on race, appearance, and name, as well as perceptions about language and role from coworkers, patient families, and leaders. Sheila reflected,

> People make a lot of assumptions, and I think that's the issue. And I don't know how we educate people more because one thing I've learned over the years, feelings are feelings; you can't tell somebody how they're supposed to feel. You may not think that they should feel that way, but they do. So it's so very, very hard to change how someone feels. I don't know how to get to that.

Amy shared an "offensive" example from 10 years prior when one of her friends, a Hispanic nurse, was accused of stealing following a reported theft and "was questioned very heavily, very aggressively, 'We're pretty sure it was you. Was it you? Did you take these things?'" It seemed she was being singled out and people were making assumptions that she was less educated or more prone to stealing because she was Hispanic. Amy was horrified and upset that her friend would be accused of stealing and "felt pretty confident that she had just as much character and integrity as any other nurse, if not more."

Another assumption occurred when hospital staff began speaking Spanish to Latino patients and their families. This made Sarah feel "embarrassed and uncomfortable" because

> they are coming to us for help, and that's just an assumption that people shouldn't make because it is a microaggression. Whether they don't mean it to, and I know it's not maliciously intended, but it can definitely be offensive to some of these families.

She observed that sometimes families roll their eyes when this happens, which makes her cringe. Additionally, Eileen felt offended for families when nurses continually offered an interpreter to speak to families after they had declined it. "Even if people have a thick accent, it doesn't necessarily mean that they don't understand English or aren't willing or able to speak English." She was culturally sensitive to this, as her parents came to the United States and had accents but speak English well. She added,

> I think if someone doesn't want an interpreter, who are we to insist that, sometimes it just takes a little patience and understanding and for people to

> automatically assume, just because they have a thick accent, “Oh, they definitely need an interpreter.”

In her role as a charge nurse, she advocated for patients in this regard. Conversely, Jen noted that staff would assume certain nurses speak Spanish based on their appearance and would ask them to translate for families who speak Spanish. Nicole likewise noted that staff would “make an assumption before really walking in the room, seeing a last name and being like, ‘Oh, do I need to get the interpreter?’ Do you? I don’t know. What made you ask that?”

Nurses in this sample discussed an assumption and added burden when Spanish-speaking nurses were assigned to care for Spanish-speaking patients. Rachel felt

> they [patients] feel validated. They feel seen. But it’s also do those nurses feel comfortable always having ... One of my coworkers who does speak Spanish, she just says, “I always get the Spanish-speaking patients.” She’s expressing to me that that’s an objective layer of extra burden that she is faced with it. But she’s just kind of gaslit that it’s like, “Well, this is what it’s to be a good nurse.”

Rachel has observed patient families assuming that foreign nurses are inferior:

> Where my coworkers who have accents or well, I guess people assume they’re foreign born, who knows if they are or not, but they have strong accents. I have experienced where I’ve heard where the families are much more aggressive towards them about interrogating where are they from, whatever, and then, I think, making racial assumptions and assumptions about quality of care about that. I witness my other coworkers who are nurses of color also, especially the ones who have accents and were maybe foreign born, I think that I witnessed the families treating them worse and just questioning, “Do you know what you’re doing?” or, “How long have you been a nurse?” I think that that also is a kind of microaggressive comment if it comes with a preface of, “Oh, where are you from? How long have you been a nurse?”

Sheila recounted that during a conversation with nurses about investments and saving money, an assumption was made when “one of the White girls said, ‘Black folk

just don't believe in saving money, do they?' And I'm like, 'Where'd you get that from? What made you say that?'"

Nurses were also recipients of racial microaggressions in which assumptions were made. A few Asian nurses specifically mentioned that they were frequently confused with other Asian nurses, or that their peers did not even bother to try to get their name correct, whether in conversation or on the nursing assignment sheet. Hannah experienced being called the name of another Chinese nurse by multiple coworkers within her department and from other departments, even years after the other nurse had left the organization. This was uncomfortable and "frustrating just because we have a similar demographic, but look totally different, we're totally different people." She was also asked if she was twins with another Chinese nurse. These assumptions "definitely feel less humanizing, and I want people to know me for who I am, not where I'm from."

Similarly, Scott noted that people would automatically assume he was a certain ethnicity or would speak a certain language based on his appearance. People frequently assumed Jen is Chinese and could speak Chinese, and "some Asian family, they always assign me to that patient, but I cannot speak their language." She found it uncomfortable being asked where she's from, but "I don't think they mean to harm you, but they don't know." Others have mentioned to her that they have seen videos online and would comment, "Oh, I saw the video. Like Asian people, they eat dog," which prompts correction.

Jen shared that during COVID it was hard. "So when they look at me and look at the Chinese and then sometimes they're like ... They have the feeling that we are bringing all the germs to this country."

Amy shared an example of being asked in conversation about a U.S. historical figure and listing several facts about him. Unbeknownst to the coworker, she had studied history as an undergraduate, but the coworker made assumptions about her knowledge:

> She just looked at me and she was like, "How do you know that?" But she said it kind of in a derogatory way. And then she followed it up with, "Oh, you had to study for your immigration test. That's why you know all of those things."

This comment was very offensive to Amy, who felt like she was being singled out and felt diminished. Moreover, Amy felt this coworker would not have made this comment if she hadn't been Asian or looked different. During this microinsult, she felt offended that someone made judgments about her knowing nothing about her. This example illustrates an unintended consequence of microaggressions, that although the speaker may not mean to make someone feel bad, these types of comments can be very hurtful and insulting.

During a conversation with some coworkers, an older White nurse commented to Sarah that the reason she received a scholarship was because she's Hispanic. This was frustrating to her, "I am Hispanic, but I worked really, really hard for everything, so it just undermined that entirely, which was very frustrating."

Sheila noticed a common assumption that Black people are going to be late. She felt that although it was expected that Black people would be late, they were also not acknowledged for being early, adding that she had learned not to apologize when she was late to a meeting. "You just walk on in the meeting, be quiet and you do your thing because we bring attention to that when you really are trying not to bring attention to that." Even when she was on time,

> you kind of feel like, "Well, don't look at me as if you thought I was going to be late." I do have some means of making sure that I am present when I'm supposed to be present. So feed that positiveness to people or else you will continue to get the negative.

Additional assumptions Rachel has faced include that Chinese people are hardworking and excel as students and she has been asked why she's not a doctor. Equally, Chris is frequently assumed to be a doctor when meeting patient families. A few Black nurses were assumed to be other roles by coworkers based on race. Samantha shared one memorable experience.

> Although our badges, the big red RN on it and it was just right here in plain sight, she [charge nurse] didn't recognize me on the unit. And so she says, "Oh, did we get assigned a clerk and I just didn't know?" I was like, "No, I'm not a clerk." "Oh, are you EVS [environmental services]?" "Well, I'm in scrubs, so I don't know how I could be EVS." And I think I was so flustered by it as a new nurse, not even knowing what to say back to it, but there were other people around that were witnessing her, "Oh, are you a clerk?" And I think after clerk, it was like a PSA [patient service associate], the people on the unit that put everything in its place. Then after that it was like, "Oh, you have to be EVS." I'm like, "No." And I just looked down at my badge and I turned around and walked out of the room.

Samantha felt disrespected, hurt, and in disbelief in being assumed to be every role other than a nurse and felt "degraded, as if I didn't work as hard to be in the same place as the other RN." She believed it was also isolating to be one of a few Black nurses on that particular specialty unit. After this happened, her preceptor apologized that that had happened and talked to the charge nurse about it, which Samantha appreciated and considered supportive. Later, the charge nurse apologized for the assumption:

> Then to add further insult, asked "Oh, where'd you go to college?" then "Oh, you graduated from community college?" "No, actually I have my bachelor's." And at that point, I couldn't say anything afterwards, it just kept going. And I don't think I've ever spoken another word to her. I mean, it was terrible.

Jessica experienced a similar situation in which a unit clerk floated to her unit from another unit and asked everyone if they were the charge nurse except her.

> That encounter was weird. But at the end of the day, I was also frustrated that they weren't like, "Oh no, Jessica is the charge nurse." I don't know if I didn't feel stood up for, or if they didn't even think anything by it.

She found these situations frustrating because "even if you didn't want to assume, you could figure it out [role]. There are so many context clues to tell you what [role] I am."

A few nurses of color specifically mentioned negative experiences as new graduate nurses during nursing orientation, or while orienting as an experienced nurse in a new department. Jessica was frustrated witnessing nurses of color "being treated differently or judged more harshly" when on orientation. She noticed that if the new nurses were struggling, the preceptors would immediately involve the educator and manager:

> Just every little thing, every little nitpick would just bring them down to the point where they either left the unit because they didn't want to be there, or they were told to go somewhere else or that they weren't going to make it on the unit. The nurses know, they can feel it. They can feel when they walk into a room that, "Oh, this group of people just finished talking about me," and it makes you second guess yourself, so you're already set up for failure.

Aquarius shared her experience as a new nurse, how Black nurses are perceived on specialty units, and the lack of support she experienced during orientation.

> I just felt that how I was received was different than White or just other new nurses at the time. They were more welcoming to help them. I wasn't welcomed into the group like the other nurses were. Everything was nitpicked from when I did things. The same thing that somebody else would've done, I got reprimanded for. Every Black nurse that I know that came in orientation got extended, things like that.

She felt that she wasn't being precepted in the same way as the other nurses and "when I finally got a Black preceptor, when I was about to quit, I got everything."

She also experienced that White nurses on her unit would not ask her for help, but rather ask a nurse with less experience than her, "just because they're not [Black].... Now, I could be perceiving it this way. But, that's what it feels like. But, I've heard other people experience that as well." When talking with others about her "awful" orientation experience, Aquarius noted that people responded that all nurses experience this. "I think when it comes to microaggressions and things like that, it's easily swept under the rug" because it's easy to normalize the experience or attribute it to complaining. "I'm not complaining because my perception is reality and this is how I perceive this situation. I was very depressed. I didn't do anything. I lost so much weight." She literally marked days off the calendar for when she'd reached 1 year so she could transfer to another unit. Lastly, she said of her orientation: "I'm not even going to lie to you. I hated it. I felt like they were hazing me."

While on orientation in a new department, Brittany, an experienced nurse, felt disrespected when she made a mistake and the person precepting her got mad and started screaming at her, "Why did you do that? Why did you do that?" Her manager frequently criticized her for her work, which led Brittany to feel, "every time that I will see her, I have like a post-traumatic stress disorder, like, 'Oh my God, she's here. She's going to give again a bad comment or something.'"

At times, nurses were the source of microaggressions in making assumptions about patients, their families, or coworkers. One example is suggestion of nonaccidental trauma in which there seems to be a

> little more suspicion when it's not a White family. Unfortunately, it does happen to be a lot of the time a Latino, Black, whatever, family. So I think that that's definitely part of it and that's not helping, but it does make me sad that it's more assumed and it's almost more expected. It really makes me sad.

Sam noted these stereotypes staff may make against patients and acknowledged that sometimes she could feed into those assumptions.

> I try really hard not to, but I think that it's sometimes unfortunately just our culture in a way. Obviously that's horrible to say, but I think sometimes you do think, "Oh crap, was this abuse?" And you do maybe jump a little faster than you realize into the assumptions. So, I think that I'm not innocent in that as well.

When recognizing this in the moment, Sarah considered it a reflective measure but also felt like a hypocrite because "you get mad when people do that, but then you're thinking the same thing."

Nicole admitted as a newer nurse, she was probably guilty of not using interpreters as she should have:

> It does seem like an extra step, I think, when you're starting, but then once you realize how much it means to those families when they can understand things, and you kind of take that step back and you're like, "Oh, you just wanna understand this."

Reflecting on this made her feel annoyed and frustrated with herself, and she wished that others had called her out for not using the interpreter, which would have changed her actions earlier in her career.

Hannah made an assumption about African American experience during the Black Lives Matter movement. When she was corrected by another staff member, it made her reflect and

> realize that, one, a good moment of growth to really think back on that other people may have totally different experiences than I would in our day-to-day

> lives, and a little humility that a lot of experiences may not come so easily to other people, just based off of exactly how they looked.

Elsbeth shared when "someone came up to me for report and they were White, and I just assumed they were a nurse rather than maybe a tech or something." She felt the interaction was "awkward," as the coworker was asking questions about the patient from a tech perspective. Also, "it made me feel a little ashamed, but then also realizing how we all have biases, in the most surprising directions."

Jessica was tasked with selecting a nurse to meet with a special visitor. She selected a White nurse to participate instead of a Black nurse and shared,

> I'm embarrassed to say this. I was like, "Oh, send this person instead of this person; this person will know how to talk to them." Which at that time I was like, "I just need this to go well." Now that I look, I hadn't thought about that until this question. Now I'm like, that was probably inappropriate and actually I'm part of the problem.

When helping a family, Jessica assumed a staff member with a Latino last name spoke Spanish.

> In that moment I was like, "What did I just do?" I called her and I said, "I just want to apologize for assuming. That was wrong of me." She's like, "Oh no, it's fine. My parents speak Spanish. My family speaks Spanish. I just don't." We all learn. I haven't done it again. I will not do it again.

Similarly, Aquarius assumed some of the families speak Spanish and automatically brought the video interpreter device. "I don't know if that would be considered a microaggression, just automatically thinking just because they are, I would say, of Hispanic descent, that they would need an interpreter." A similar assumption she made was with the transgender children automatically assuming that, okay, you look like a boy to me, and I called them a boy. I don't know if maybe I could have been like, 'Oh,

so how do you want to identify?' I don't know if that's a microaggression. It's an assumption."

Labeling or Judging Patients/Families Based on Race. Patients, their families, or coworkers were labeled or judged by appearance and sometimes before an individual had met them and formed their own opinion.

Nurses were bystanders of coworkers labeling or judging patients and families when commenting on African American families being loud or being annoyed or inconvenienced about having to use an interpreter ("All of my patients need a Spanish interpreter"). Through these comments, Nicole inferred that coworkers considered using an interpreter to be difficult or a hardship. This made Hannah feel uncomfortable.

> In our very urban, diverse patient population, having in-person Spanish interpreters or technology allows us to be able to communicate well with families and being able to advocate for patients and make sure that everybody's on the same page and understanding of their care.

Another example was when staff commented on patients who were self-pay, which was frustrating, and according to Nicole, "it does play a role, but I don't think it should dictate the care that we provide."

Sam did not witness this firsthand but heard about a time in her department in which a Black patient was given a urinal as a water jug and comments were made by staff members. There were additional judgments made about multiple children in the family and low socioeconomic status. She was unsure whether this was related to race, or it may have been one coworker.

In her role, Jessica noted different responses to families based on race.

> But when you're there and you're watching, and the doctors, sometimes they honestly don't know what they're doing wrong. It's like, "I can tell you." It's how

> you're talking to them. It's how you sound condescending right now. Or they're like, "Oh, this mother's yelling." I'm like, "She's yelling, but I was just with you with a parent who was White, and she was yelling and crying and doing the same thing, and you kind of coddled her."

Invasive questions/comments. Nurses were recipients of continual invasive questions or remarks from staff and patient families. Samantha recalled a memorable encounter when a White leader made an invasive comment about her hair:

> I just never recognize you because every time I see you, your hair is completely different. And I am just so envious of Black women because you all just get to do whatever it is you want with your hair and come to work.

Frequently being questioned about her background was bothersome and hurtful to Jen: "They do not mean to harm you, but they don't think that it still bothers you. If they ask you the same question over again, it's just hard to try to explain to them over, over again the issue."

Rachel was frequently asked,

> "Oh, where are you from?" I get it a lot from patients and their families. For me, I think it's awkward sometimes because I'm from New Jersey. That's where I grew up. That's where I lived my whole life.… But usually when they ask that question and I say, "New Jersey," well, you can tell that they're not satisfied. Sometimes they actually even overtly ask, "Oh, no." And then they'll be like, "That's not what I mean."

She was not always sure how to respond but replied with an answer she felt comfortable sharing. "I usually understand what people are asking, and I don't really read into their intention. But I just basically tell them that, 'I'm from New Jersey, but are you wondering if I'm Chinese?'"

Rachel then shared how she dealt with this daily:

> I'm used to it at this point and just I know what I'll say and push back on them a little bit and just be a lot more direct.... I feel a lot more comfortable when I am

> the one who's directing it and ask them questions back like, "Well, what do you really want to know? What are you asking me?" It actually disarms them a little bit. I think that it makes them feel a little awkward about asking that. I don't think that I have to clarify that for them. It just feels like I just want to get it over with and I don't want to be interrogated further.

Theme 2: "Firing" the Nurse

Several nurses in this study were bystanders who had heard of patient families refusing care from certain nurses, or "firing" them based on their race. Nicole recalled a situation a few years earlier in which a family refused care from an Asian nurse, which was "frustrating and truly originated from a bad experience with one person and became many of our nurses." Palmer explained that families will talk to the charge nurse, "Oh, I don't want this nurse, I don't want that nurse" because of their nationality and further commented that she'd never had that experience before with a family, of being "fired." Amy recalled hearing about a Middle Eastern family from the United Arab Emirates who didn't want their child being cared for by a Black nurse, adding, "It's definitely aggression in the workplace, knowing that some families feel that way."

Palmer noted that

> a couple of people have really strong accents and they'll [parents] come out and say they want another nurse; they say they can't understand. And so then you're the charge nurse saying, so what am I supposed to do about that?

Similarly, Rachel assumed care of a patient after "this family fired this one nurse who was one of my coworkers, but basically requested a different nurse who was not from this country and had an accent and was Black" and noted that the family seemed much happier having her as their child's nurse. She summarized the family's perception of her as an Asian nurse: "They understand that cultural background [Chinese], and they feel like that person is going to be a good nurse versus the implication that they're

insinuating that because she's foreign born and because she's Black, she's not a good nurse."

After a Black nurse was "fired," Rachel assumed care of the patient and noted,

> There's just that undercurrent of, even though they're [family] not saying this stuff, I can understand that they're happy with a Chinese nurse because they have assumptions that I'm passive, permissive, and will just do whatever they tell me to do, and I'll be subservient. That doesn't make me feel also good because I'm also then in that racial dynamic.

The concept of firing a great nurse was "ridiculous" and made their coworkers feel awful. Katherine remembered thinking to herself, "You guys are crazy. That's one of our best nurses," and although the specific nurse was someone who'd let things "roll off her back," her peer felt "that's awful … to discriminate against somebody just because of where they're from."

Theme 3: Questioning Experience or Credentials

Nurses were recipients of persistent questions by coworkers and patient families about their skills, credentials, and experience, with one patient's parent verifying the nurse's role with a physician. This experience did not occur for White nurses in the sample, but only nurses of color.

Brittany recalled being treated like she was a new nurse when she first came to the United States as coworkers and patient families questioned her experience.

> They will ask you, "Where you came from? How many years of experience?" You can tell from the sense, the tone of voice, you just can feel it. And then there was even one male patient at the time that I felt like being bullied by a patient.

Since she was older than the patient, she wondered, "'Why is he doing this to me? You don't have respect for elders?' That's how I felt. I mean, we cannot do that in my

country. You cannot do that to elders." Similarly, Jen was asked by parents, "Do you know what you are doing?"

Years ago, Sheila was asked to manage a program, and the leader was "a little hesitant, and the person who recommended me to manage the program was wondering why she was hesitant." And her comment was, "Do you think she has enough schooling for that?" Sheila wondered what that comment meant but felt that she had a great advocate in the leader who had recommended her and vouched for her capability. She later felt unsupported by the Caucasian leader who withheld information needed for the project, "as if she just wanted me to fail. It was really interesting, that whole dynamic." Sheila scheduled appointments to meet with the leader who declined the meetings and as the deadline approached, Sheila "did what I had it to do to get the information in. She [leader] tried to sabotage me and then said that I put the organization at risk."

Chris noted:

> There are times I have run into situations where I'm working with a minority family and it would appear that they're not paying attention to me because of their perception of like "Here's a White guy telling me whatever to do for my child." But then other staff members will go in and I will see them react very differently to the things that they are saying.

He felt the families were questioning his experience, noting, "It was just a barrier that I could not quite understand. You know, I'm just going in trying to do my job but there was just a wall there."

Upon introducing herself to a patient family, Sam described, "I'm going to be your nurse that's taking over.' And she looked at me and she said,

> "Oh, really?" She's like, "Are you sure you're a nurse?" And I was like, "Yeah, I'm going to be taking care of you and your child today." And she said, "Well, are you sure? Typically people like you aren't nurses."

Then the patient's mother requested to see the doctor (a White man) and asked him to verify whether Sam was a nurse or a tech or housekeeping staff. Eventually the mother accepted that Sam was a nurse, but said she was "not like the others." Sam asked her to clarify what she'd meant by that and she replied, "'Well, others that are you.' And it took me a second to realize what she meant, but she meant other Black nurses or Black employees at the hospital." This encounter made Sam feel

> a lot of confusion and a lot of hurt, honestly, just because you would think in this day and age, we wouldn't be going through this, that people still feel this way, I guess. But it's definitely something I've still thought about over the years just because it's, everybody puts in the same amount. Like anybody can go to nursing school. Our backgrounds don't define who we are.

Sam also witnessed patient families make comments to coworkers like,

> "Wow, you're really different from other people, other Black people," or not in those words. Or like, "Oh, how did you get here? How did you become a nurse?" Most often people don't believe you're going to be the nurse who will take care of the patient.

An experienced nurse, Aquarius felt that she was always questioned or second guessed by patient families:

> Oh, so how long have you been doing this? Even when they're talking to their children, "Oh, well, they're experts in this, aren't they?" But, it's like your skills are second guessed, like your expertise, because I don't know what they've heard or the negativity that comes along with Black people. It's kind of irritating to go into having your skill set. I worked hard for this. I know it. I'm not going to hurt your child.

She felt this was insulting and draining and the comments often passive aggressive, but "I'm going to be myself and I'm going to still treat your child how I would want my child treated." She described a double standard that exists in which the patient families automatically accepted the experience of her White manager but

questioned her and other Black nurses in her department. She found these comments to be annoying and frustrating and things she and her coworkers "deal with on a regular basis on our unit. But, I understand why it's happening, but why does it have to happen?" She also experienced physicians questioning her experience in asking whether she understood an order. "'Oh, are you sure you don't need my help to do...' No, I can read orders. If I have any questions, I would definitely come to you."

Theme 4: Where Do I Belong?

Several nurses wondered where they belonged within the context of race and within the organization. In this theme, nurses described interactions in which they were the recipient of microaggressions. Rachel noted,

> As somebody who already has confusion about their own identity, I guess, in terms of where they fit in the landscape of this country and being not born here, but being raised here, … there's things that are confusing about which social group do I fit into? Am I a person of color?

Eileen observed, "What I noticed that people who kind of look alike, I guess, tend to be more comfortable around each other and not very inclusive. So I think that's a perception."

Elsbeth noted that the techs were more likely to look like her, whereas most of the nurses on her unit were White.

> And the techs tend to eat in one room, and the nurses tend to eat in another room. And so, it's not anything that anyone's planning or doing purposely. But then as a Black nurse, you're like, "Oh, should I be eating with my techs? The people who I'm like, 'Okay. Maybe I'll have more,' not more conversations with, but should I be eating there or should I just go in with the nurses?" It's a weird thing that goes through my mind. And I don't know how much of it is just me internally or the way the environment is.

Jessica noted,

> You have to connect with them [White nurses]. I think a lot of, especially when you see nurses or you have nursing students [of color], they're like, "I'm used to hanging out with Black people" and you want to find your people. When you go somewhere and you're one of the only Black nurses and you see Black people, you're like, "Okay, let me find. Let me connect."

Similarly, Samantha shared an occurrence on another unit where she'd worked:

> They had a thing at night where they would order food, but it would only be the White nurses that would order food together. Then I found out they had a group text that they organized it on, but they excluded me, although there was the work phones that they used. But then the Black staff, the clerk and then the PSA [patient service associate] were also not included. And so the nurses would sit in the break room where I thought that I should be sitting with the nurses, but then I would come in like, "Oh, you guys ordered food?" "Oh yeah, we just thought that you would want to do your own thing."

Samantha tried not to let this bother her since she still had to work on that unit but couldn't help but wonder if it was "about race or if this is just a coincidence."

Eileen remarked,

> You like a job, but then sometimes you just don't feel like you really belong, or people take the time to get to know you. But I feel like my manager can be a little like that. She feels comfortable around people who look like her. The last few people that she's promoted have been people that look like her. And I'm not trying to say that, I've never applied for any of those things, but it's a little unsettling when you think, "Oh, well, the reason that person got that job is because she's friends with so-and-so."

On working on a specialty unit, Aquarius received negative comments from other nurses:

> You're a Black nurse, you're supposed to be on med surg or do ... No, I want to do this. Then they look at you like, "What you doing up here?" That's the feeling that you get, like you don't belong up here. It's hurtful. It's a hurtful feeling. But, being Black, you are used to certain things and you just suck it up and you go with your day, do what you have to do. But, it doesn't feel good.

She noted her experience was not unique to this organization, as Black nursing friends working in other hospitals also "hated it."

Theme 5: All Jokes Have a Grain of Truth

Nurses described interactions with coworkers that included jokes about race, sometimes intending to be funny and other times coming across as mean and hurtful but disguised as a joke. Jokes occur with comfort among people of color (POC) and "it's usually a little bit more racial microaggressions within the POC group. I think the White nurses are more, 'Let's not even touch that area." Scott described this racial awareness, such that White people must be careful and cannot participate, but POCs share a common experience and can speak freely within their group. Eileen noted that though her workplace was very diverse, "I feel like I've had a couple of things said to me that I kind of wasn't even sure if it was said to me in that way in a joke or whatever, but still, I was offended."

Racial microaggressions are problematic in their subtlety and according to Amy,

> They're not being made by people that I think are malicious or unfriendly. I think it's just a lack of self-awareness that that could be offensive to somebody. I think they were just trying to make a joke. But it didn't feel good. I maybe smiled on the outside, but inside it was like, "that wasn't very nice."

Similarly, Elsbeth noted, "Because all jokes, or many jokes, they have this grain of truth or something that people believe is truth, and that's what makes them funny in a way." Chris supported this notion: "I think they do it because they think it's funny. But it is more of an offhand comment." He added:

> A lot of misunderstanding and assumptions and stereotypes and then people hearing other people say it and thinking it's okay for them to then exhibit the same behavior, and even when it's done in a funny way, you know, some staff members have a great sense of humor about things but sometimes it can be offensive.

Aquarius reflected,

> Growing up, you're just used to living this way. As much as it's... I know that it's subtle things and somebody else can just be having that same interaction. No, well, actually that's what makes this a thing. Because, it's like you're trying to joke about it and be like, "Oh..." I smile and it's really not funny. You're really insulting my intelligence by doing this. My manager, it's like she's looking at the same situation and she doesn't see anything wrong with it because, yeah, you won't see anything wrong with it because it doesn't happen to you.

Scott admitted to potentially being the source of a racial microaggression when joking around with colleagues, but it was in jest and he made sure "that they're laughing as well, and just being really cognizant of if they're feeling uncomfortable." While made in a joking manner, racial microaggressions can be unintentionally offensive.

Responding to Racial Microaggressions

Nurses recounted responding to racial microaggressions as a recipient, bystander, and source, supporting the standpoints identified in the microaggressions triangle model. Overall, nurses were more likely to respond to racial microaggressions as a bystander compared with as a recipient. This is because the recipient may not feel comfortable speaking up for a variety of reasons, including not knowing how to respond, timing, and power differentials. Nurses responded to microaggressions in several ways, which included speaking up, correcting an assumption or educating in the moment, intentionally avoiding conflict by using humor or giving people a pass, and showing support as a bystander or seeking support as the recipient. Finally, nurses reflected on how their years of nursing and/or life experience impacted their response to racial microaggressions.

Theme 6: Not Being Silent

Speaking Up

One response participants employed was speaking up to the source of a racial microaggression to interrupt the behavior and invite a discussion. Nurses in this sample shared examples in which they'd spoken up and some of the challenges they felt about speaking up, particularly while providing patient care. Additionally, nurses were more likely to speak up as a bystander to defend a coworker or a patient than reply when they were the recipient of a microaggression.

Speaking Up for Others. Participants considered speaking up as the bystander of a microaggression to be safe and the right thing to do to support coworkers or patients.

Scott was less inclined to speak up as the recipient of a racial microaggression, but "when it happens to others and it feels weird, I'll be like, 'Boy, let's cut that off. Let's try to steer the conversation away from that.'" Equally, Amy reflected,

> I'm realizing that I'm more apt to speak up if it's happening to someone else and I feel the strong sense of injustice. And if it happens to me, I just sort of smile and pretend it's not happening. So that's my personal bias, it's easier to say something if it's happening to someone else. And harder, for me, personally, to say, "Hey, it's really not appropriate," if it's a behavior directed towards myself.

Brittany was also more likely to speak up to support a coworker: "I don't know why, if for other people, I can, but for myself, I cannot talk." Eileen agreed, "It's easier for me to kind of advocate for a fellow staff member than it is for myself."

When Jessica questioned the nurse leader who commented on the social media page of a nurse from her unit, the leader became uncomfortable and changed the subject. "If something is being said that is really inappropriate that could affect me as a Black woman, I'm going to say something."

Similarly, Nicole would speak up for patients:

> I was definitely very shy and reserved when I started [nursing]. That's no longer the case. And I think the more experience that I've had, not only in nursing but in life, the more likely I am to speak out when I see something that I feel is wrong or unjust, especially for our patients.

Speaking Up for Oneself. Nurses shared examples when they spoke up to address a microaggression as a recipient, including when being called the incorrect name or being assumed to be another coworker based on race.

In being called the name of another Asian nurse, Hannah recalled, "in those moments I spoke up like, 'Nope, this is my name. And that person hasn't been here in years.'" When called a completely different name, Scott would correct them with, "'Oh wait, that's not my name.' And they should know better because I've been here for 3 years." His tone shared the hurt and annoyance he felt because of this frequent occurrence.

When her friend was accused of stealing, Amy responded with, "'That's not right. That's wrong.' The reply from the source was denial: 'Well, we were just checking.' They didn't feel bad. They were just like, 'Well, we were just innocently asking.'" This interaction was so memorable that Amy remembered it vividly 10 years later because she was "horrified that people behaved that way."

When a White coworker commented on how her White children would be at a disadvantage, Eileen replied, "Well, I don't think any one of these kids, mine are Asian, are they going to benefit?"

Equally, Jessica would reply, "That's racist. You can't say that, that's racist" to a coworker's joke, but hesitated to speak up too much because "I don't want to be that person, so I didn't speak up as much."

When she was yelled at during orientation in a new department, Brittany approached the coworker and said, “I don’t like what you did yesterday. We are in front of other nurses. Why do you have to scream at me?” The coworker replied by blaming her for the mistake she had made. Then, Brittany escalated the incident to the manager, expecting them to seek additional information, but they asked if her previous position was still open and if she would like to go back there. She felt that this was due to her race, since she was “the only brown one there.” The chain of command was one approach Brittany used when responding to concerns.

Correcting an Assumption/Educating

At times incorrect assumptions led to microaggressions, to which nurses responded by correcting the assumption or providing education. Nurses typically engaged in education and viewed corrections in that vein rather than as confrontational.

When a coworker assumed she’d received a scholarship because she was Hispanic, Sarah replied, “No, I actually got my scholarship because I’m quite intelligent and I worked really hard for it. I was involved and very, very committed to my education.” No one else in the group said anything, though it seemed to Sarah like others were uncomfortable during the interaction. When people asked about her credentials, she responded by being professional and explaining that she graduated from high school, went to nursing school, and started working at the hospital. Similarly, when parents questioned her experience, Aquarius commented,

> At the time, I’m doing my job. I kind of blow it off unless I’m very frustrated. But, I’m not really a mean person or anything like that. But, I ignore or I’m like, “Ma’am, all the nurses have ... I’ve been doing this for a while now. Your child will be fine.”

Nicole felt annoyed when her coworkers seemed inconvenienced or reluctant to use a video interpreter device:

> We'll call them out on it, kind of be like, "If it's that hard for you, I can call. If it's really gonna be that big of a barrier, I can do that extra step if that's what's stopping you."

Sheila tried to explore a White nurse's assumption about money mismanagement, asking:

> "What made you think that way? Where'd you get that from? That's something did you grow up knowing about?" And it was really hard, the exchange, because I couldn't get any answers that made me feel like she really knew what she was talking about.

In the moment, others seemed shocked that the comment was made, but Sheila was upset and felt the need to educate the White nurse.

> Sure, I will agree with you. White folk got money from inheritance, okay? I don't want to get into this racial background with you. White folk know a lot about stocks. Our folk know a lot about real estate, but it doesn't mean that we don't know how to save or we can't save. We just were taught differently about certain things. I guess she was okay with it, but I didn't let it stop there. I was like, "Let me just educate you a little bit."

When asked where she was from, Rachel replied, "'Oh, do you mean am I Chinese?' And then they'll be like, 'Oh, yeah. So you're Chinese.' And then I think a lot of the times it's coming from a place of curiosity."

Hannah felt her years of nursing experience created a platform for education:

> Still in an environment where people might view me, or make assumptions about me, based off of how I look, and I try not to take that personally, and take it as more of an education of a moment to educate someone on who I am.

When assumptions were made about the nationality of her coworkers and what language people speak, Jen corrected them. Chris also tried to correct staff when hearing

comments like “anchor babies,” adding “not usually in front of a family but having a separate conversation like, ‘I don’t think that was really appropriate to say.’” Staff would usually look at him incredulously and he would reiterate, “You can’t say that; that’s not appropriate.” He further shared,

> In some ways I’ve gotten more savvy at it and I’ve gotten the confidence to correct some of the things.… But also my years of maturity gives me that professional maturity to try and make sure I don’t fall into those traps.

As a leader, he also felt that he had an obligation to address racial microaggressions: “I feel that because I am in leadership, people listen to me differently than if I was a bedside nurse.”

Sam also saw an opportunity to provide education and mentorship:

> I think that it’s helped me be a stronger nurse in a way because I know that I can still care for my patients. And at the end of the day I know that I can stay professional, I can provide the best possible care without really focusing in on it, but also I can use it as a platform of education, even if it is just passively responding or giving facts of, “Well, I went to nursing school,” or “I have this many years as a nurse; I’ve done this many things in my career. I’ve been an educator, I’ve been a bedside nurse, I’ve been a charge nurse.” So I think it honestly makes me a stronger nurse and it helps to be able to be there if this did happen to a younger nurse to be able to mentor them.

Samantha credited her experience for helping her to advocate for herself and others in addressing microaggressions:

> I think after being exposed to the events that I have been exposed to, it’s helping me to better find words to address it when it happens versus just being avoidant of it. So I’m not perfect yet, but I think it is actually starting to help me to find ways to respond so that maybe the person doesn’t even realize what they’re saying is racially offensive or hurtful.

Theme 7: Intentional Nonconfrontation

Nurses in this sample sometimes made a conscious decision to refrain from confronting a source of a microaggression depending on timing and the desire not to cause conflict.

Hannah poignantly shared, "Because, from my experience, sometimes I don't always feel comfortable speaking back to the person who's made me uncomfortable and letting them know that that was not right to say." Because microaggressions are "salient," responding to them is challenging. Elsbeth commented:

> In the moment you're like, "I don't know how to address that. Or that needs to be addressing. Or they mean the way I thought they meant it." Am I going to make a big deal out of nothing? So they're particularly difficult to handle.

Some nurses avoided conflict, like Samantha, whose approach was "not saying anything because I don't want to then say something and then I come off as aggressive, abrupt," mentioning that she had been trying to improve with addressing microaggressions. She acknowledged the struggle:

> Sometimes your emotions are so high like, "I can't believe this person degraded me or thought that I was less than who I actually was." I don't want to say anything because I don't want to come off as the aggressive party.

When a physician leader made racist remarks, Samantha felt that she could not speak up, as the leader controlled departmental funding "so I just always tried to stay out of her way." Equally, Eileen noted, "You want to maintain professional boundaries and behave professionally. So I don't think calling people out on that type of stuff or bringing more conflict or stress to the situation is the answer."

Amy provided another rationale for not responding to a microaggression. "You're sort of shocked and you don't want to make things worse by causing a scene. Or, I don't

anyway. I mean, people do, but it doesn't seem helpful." Eileen offered a possible reason people may not respond to a microaggression:

> I don't have any concrete examples, but I just feel like there are people who always want to play devil's advocate. So when you do speak up, you almost feel like you have to try to defend yourself a little bit.

Using Humor

Humor was a strategy some nurses used to respond to racial microaggressions, which came as a natural reaction to an egregious comment.

Jen avoided conflict by using humor to address assumptions about her race or the food she ate: "I try to use humor and make them laugh a little bit, laugh it out, like you say, laugh it out again, just move on."

When a leader commented on her hair, Samantha did not know how to reply, but said, "I guess that's just the wonders of being Black" or "That's just the magical part of it." "I think that's all I could say, because I'm like, 'Do whatever I want to my hair and come to work,' that's not accurate at all." In that moment, Samantha wanted to believe that the comment was well intentioned:

> I hope that it was just that she felt comfortable with me to say it and that it wasn't offensive. I don't know that she would mean it in an offensive way. I don't know what to make of it.

Afterwards, she considered a nonconfrontational response: "'No, we don't really just get to do whatever to our hair and come to work or whatever we want,' but in those moments, I just don't have the words. I'm almost in shock that it's even being said."

Giving People a Pass

One way nurses intentionally chose to not respond to racial microaggressions was to give the source a pass.

When a non-American family mentioned that White nurses were better, Elsbeth did not respond but let it go, giving the family a pass since they were from a place in West Africa where colorism still exists. This happened while she was on orientation, and after leaving the patient's room, her White preceptor noted that the comment was not appropriate. Likewise, Sam responded to mistreatment by a patient's mother by "brushing it off."

When called a name like his, Scott would respond, "I'm just like, 'Whatever,' I let it go, because I think that's close enough." He felt like he could compartmentalize these comments, "Okay, this is just what people say. Whatever. Move on." He also shared that he has experienced the "model minority probe" and that the things he's heard have not been hurtful.

Nurses were asked how their years of nursing experience have impacted them in dealing with microaggressions. One nurse felt her experience gave her perspective "to maybe give other people that I interact with a bit more grace." Amy felt her experience helped her respond with a level of maturity, realizing that these comments may come from a place of insecurity or lack of education.

> Rather than feeling diminished by them, I think I can sort of separate it out and see now that ... the saying of "hurt people hurt others." I can sort of see, they're maybe not coming from a great place. And that's what leads them to be less sensitive and less self-aware of how their comments might impact others.

Eileen summarized how her years of nursing experience helped her deal with microaggressions.

> I'm a little more aware of how certain groups or certain cultural backgrounds will react to me, but in some ways as I get older, it's more difficult because you want to do a good job and it's hard. I think people get burnt out. As I get older, I think

> it's harder in some ways, but easier. I'm more knowledgeable, but at the same time, on an emotional level, it's more exhausting.

Theme 8: Showing or Seeking Support

Support was either demonstrated or sought in several ways based on the perspectives of those experiencing a microaggression. For example, bystanders showed support for recipients in the moment or afterwards, while recipients sought support from coworkers or family members, and the source showed support through an apology after reflecting on what they had said.

When the family from the United Arab Emirates did not want a Black nurse caring for their child, the bystander response was support and advocacy of their colleagues. Amy was proud of the reply, noting,

> They were like, "At [hospital], every member of our team is respected. And if you would like a nurse that is not Black, you're going to have to go somewhere else. We don't assign nurses based on race or take away work opportunities based on race. So how your family operates, you're free to make a different choice."

Equally supportive of staff was another unit's response when a family refused care from an Asian nurse: "People are going to have preferences, but we are a diverse hospital. We care for a diverse population." In addition, the nurse was moved to another part of the unit to physically separate her from the situation.

In her experience, Amy had not witnessed a bystander speak up when a racial microaggression was committed against her, but had received apologies afterwards, "which is interesting because then there was some later self-awareness that even though it was meant to be a joke, it could still be harmful. So I appreciate that."

One apology occurred after nationally publicized anti-Asian hate crimes:

> It was actually when a lot of that was in the news that that person came over and was like, "Hey, maybe ...," I mean, something must have clicked in their head, like, "Maybe I have these stereotypes that I think are funny, but maybe you don't think they're funny. And maybe I shouldn't have said them." It was during that time period in our culture or national narrative.

Sheila referred to her exposure working in the community and with marginalized patient populations where she had to advocate for others, "and I think that's really helped me, helped me to not only deal but to advocate."

The ethnic and racial background of nurses and their previous experience with racial microaggressions played a role in their experience with workplace racial microaggressions. When people have "had a lot of experiences with racial microaggression, you're not going to be trusting or feeling valued. You have to work through those things."

For example, when a patient's mother commented on "chinked" eyes, Hannah was upset in the moment, commenting, "not that it would be any better saying that to someone of a different race, but they're definitely saying that to someone who's experienced people saying those types of words before." The experience felt "demeaning and dehumanizing" and because it was so blatant, it was "definitely shocking." Hannah further noted having these feelings while providing care for the patient. Elsbeth wasn't surprised when a non-American family said White nurses are better. "It was something that growing up, you might hear a lot of. That White is smart and capable and pretty and all of that." As a result, the comment didn't "really strike me that hard. It didn't affect me that day."

A nurse who grew up in the Caribbean and moved to the United States as a teenager reflected, "Moving to America was quite an experience because it's the first

time you're a minority and your color starts to matter, and you realize that people are interacting with you or making assumptions about you based on your color." After other students in graduate school commented on her race, Elsbeth felt insecure and fearful to the point of thinking every time she raised her hand in class, "it's not just me speaking, it's like me, a representative of all Black people. And if I say something dumb, then it's like, 'Oh, there we go. Black people are dumb.'"

Scott experienced that "a lot of people just don't pronounce my name right, and I've gotten that all my life, so I'm not taking that to heart." Further, he let "a lot of stuff roll off my back. If it's not overt and it's not with bad intent, I don't care about it so much, because I've dealt with it my entire life."

Brittany was bullied by a teenage patient and felt,

> In my country, I really don't have that. I cannot speak up or something. We have to wait first until such time. If it's more than that, then you can speak up. But if it's something that you can tolerate, we tolerate first, basically.

In this case, cultural norms affected her ability to respond to a racial microaggression.

Aquarius shared, "It's annoying. But, being Black all my life, you kind of get used to those things. As frustrating as it is, it's like you get used to it. It's not just work. It's everywhere for us." Sam noted, "I guess you grow up and you deal with things like this your whole life in nursing and outside, and at least for me, it's just whatever, people are going to have their own mindsets."

Addressing Microaggressions Using Personal and Professional Strategies

Nurses in this study employed both personal and professional strategies to cope with racial microaggressions in the workplace. These included seeking support from

peers, leaders, their families, and the organization, refraining from judging or labeling colleagues and patient families (bracketing), communicating thoughtfully to build trust, and doing more to be perceived the same.

Theme 9: Empowering

Nurses shared comments made by patient families, coworkers, and leaders to which coworkers and their family members demonstrated support or shared how they have or would support coworkers if they witnessed a microaggression. By debriefing these experiences with workplace racial microaggressions after they occurred, nurses felt validated and empowered. Some nurses used mentoring as a strategy to empower nursing students to navigate their nursing programs and transition to practice.

Coworker Support

When being called the name of another Asian nurse, Hannah did

> bring that up with a couple of my coworkers, we were talking about it, and it was just so blatantly that we do not look anything alike that it just again, made me definitely feel smaller, made me feel like I'm not my own individual.

Sarah felt supported when questioned about receiving a scholarship when the nursing student who was shadowing her commented, "That was really, really rude. I'm so shocked she said that." She later discussed this with some coworkers in her unit and they provided support and validation that the comment was rude and ignorant.

When Nicole witnessed a coworker get "fired" by a family, she consoled the nurse, offering to speak with the charge nurse to escalate the situation, offered to be as involved as the nurse would like her to be, and "for several shifts after that, and even outside of work, I remember checking in with her." When a patient's mother questioned

whether Sam was a nurse, she talked with coworkers during lunch and learned it had happened to someone else earlier. “And it was just one of those things where it’s like, you know, what happens but until it really, you’re thrown in the middle of it, it makes you just stop and be like, ‘Wait, what just happened?’”

Jessica responded to a nurse leader who commented on a social media page of a Black nurse, noting, “We’re both Black women and I wanted to nip that in the bud.”

When she was about to quit during orientation, a Black nurse with years of experience on the unit saw Aquarius about to cry and asked her what was wrong. When Aquarius explained the lack of support she felt, the senior nurse replied, “Well, before you quit, I’m going to talk to the managers and see if I can take you. Because we need you on the unit.” From that point, that nurse became her preceptor and “it was a whole 180. It was totally different.” Aquarius also found support in talking with other nurse residents in her residency cohort and learned that Black nurses on other units had a similar experience.

When patient families questioned her experience, Aquarius noted that some of the physicians had shown support for her and other Black nurses in her department by telling the families how amazing the nurses in the unit were. While she acknowledged the physicians meant well, she wondered, “But, would you have to go above and beyond to do this for other nurses of other races?” She also felt support from her manager, who did not tolerate families treating the staff disrespectfully, and would personally speak up in support of a coworker. As a bystander,

> If I saw something happening to you, I would have to say something. So, that’s just how I was raised. I don’t want to see anybody treated bad. Why are people treating me this type of way? Because, I would never treat somebody like that.

Due to the toxic culture on her former unit, Jessica supported coworkers by discouraging others from applying to the unit.

> It was at the point where I was turning people away from that unit, which is not good because you can't grow the diversity on the unit if you don't bring people in. I tell that to people who are there. I'm like, "You can't mess up at all." You never tell people that. It's always like, "Oh, it's okay to mess up." No, we can't mess up. Especially if you're in orientation, you need to be on your Ps and Qs. Don't sit around chatting with the techs or in the back. There's nothing wrong with that, but it's just how it's perceived. Everyone is watching you. They're watching you. You can't do what your White counterparts are doing right now. Just get off orientation, make it off orientation, and then you can relax.

Aquarius liked to help people and served as a mentor to Black nursing students and nurses. She offered to mentor through her school, as a lot of minority nurses graduate from its program and are willing to listen or discuss potential shared experiences. Jessica also mentored Black nursing students and nurses and felt that "it's good to remember these things for me so that I can kind of talk it through because it's going to happen again. It's going to happen to someone else again. It's going to happen to me again, unfortunately."

In frequently dealing with microaggressions, Rachel noted a

> solidarity amongst all the nurses who understand this, a little bit of a shared experience. It's a shared experience, and there's a huge range, from outright aggression and racism that is present, to these forms of microaggression that are just irksome and annoying and that people who are in the predominant racial group don't face.

Family Support

Despite feeling hurt and disappointed by a negative experience with a leader, Sheila had a mom

> who backed me and said, "No, you're not going to let that be on your record. You need to take that higher." I had a mom who, she experienced all that. She was like, "No, you're not going to let that happen to you."

Her mother encouraged her to escalate a negative experience with a leader to human resources (HR).

Brittany shared her upsetting work experiences with her family, with her young adult daughter noting that tiredness from her previous job was replaced with many emotions after working in a noninclusive environment where she felt targeted.

After being questioned about being a nurse, Sam debriefed with her sister, who is also a nurse, and found that to be validating.

> I never really, it happened to me until then, and I hadn't really thought about it, and I asked her. Because at first, I was like, maybe I'm just overthinking it. Maybe I'm thinking too far into this situation, that's not what they meant, maybe I just heard it wrong. But she agreed that, no, that's where that was going.

Leader Support

Jessica sought support from her manager, which helped her respond to microaggressions and, in turn, allowed her to help others:

> I can't remember what the situation was, but I was really upset by it. I talked to my current manager about it and she was like, "Well, whenever they say something, just say, what do you mean by that?" I've been using that and they stop because, as soon as you say that, they know what you're asking because they knew what they meant. I think people expect that from me now so they're more careful and I'm more comfortable with... It used to be, if I'm talking about something dealing with race, I would only do it in a space where it was only Black nurses or Black colleagues. I've stopped doing that now because nothing I'm saying is wrong and it's good and it's actually really helped when, one on one, my White colleagues will come and be like, "Hey, I have a question about this," or, "This happened at home, or this is happening in my family." I appreciate that I've ... I feel like I've made a safe space for anyone. I think we should all be uncomfortable sometimes because it opens doors for conversations.

Organizational Support

Some nurses of color requested advice and support through HR to assist them in dealing with workplace microaggressions and discrimination, primarily with leaders. A

few nurses acknowledged that talking with an HR representative was a possibility but did not pursue that option. However, when her supervisor was going to write her up after she failed to provide needed information, Sheila filed a grievance with HR and shared documentation of scheduled meetings and remained factual and professional. The claim was found to be baseless, and Sheila felt supported by HR. Reflecting on the experience, she noted,

> So that the hidden stuff, the microaggression stuff that she was portraying to me in the background. And when she tried to sabotage me, I just couldn't believe it. I was like, "Really? I haven't done anything to you, lady." I don't know what her issue was with me. And the person that referred me to do the project was another African American person who was in a leadership position as well. And I don't know if she wanted somebody else on her staff to do it, I'm not quite sure. Or she was trying to sabotage me so she wouldn't get in trouble. So she was trying to put me in the middle of all of that, but it was ugly.

After that experience, Sheila received positive feedback from others for the courage to speak up and felt validated, "knowing that you were right, that some of the things that were happening behind the scenes were just an attack on who I was." Similarly, after continued comments from her manager and much consideration of whether it was the right thing to do, Brittany escalated her concerns to HR. She felt the mediation was fair and unbiased and when the HR representative suggested they both apologize to each other, Brittany apologized, but her manager never did. The lack of support and scrutiny from her manager ultimately led her to transfer to another department.

Within the study organization, staff are encouraged to submit safety event reports about bias events, which can be done by name or anonymously. One nurse in the study was aware of this reporting option but was unaware of the logistics of submitting a report.

Following an event that was reported on her unit (example not shared to protect nurse identity), Aquarius noted that the report was submitted anonymously:

> Well, I feel like when you have issues with racism and people offended by certain ..., I think that should not be anonymous. I feel like you should be able to sit down and try to talk through whatever issues that you're having so we can get an understanding. Because, just because you are offended, now I'm offended.

Instead, she would have preferred to have a conversation about what offended the person submitting the report and to come to a mutual understanding:

> I think that however you feel about it, I would respect that so much more if I could sit down.... Because, I feel like we will both benefit from that. I don't think, right now ... People are just throwing the stone and hiding their hand and it's not doing anything. And, nobody wins in that situation.

Theme 10: Bracketing

Nurses paid careful attention to acknowledge any unconscious bias they may have and to avoid labeling or judging coworkers or patients and their families based on appearance or from extraneous information that was shared in report from a previous nurse. The researcher has named this theme Bracketing, which is like the exercise completed by qualitative researchers of setting aside individual beliefs and a priori assumptions to avoid biasing a subject's intended meaning, perception, or experience. Nurses in this sample deliberately set aside any potential biases, instead choosing to approach a patient and family with a clean slate and openness in providing patient care.

Hannah shared, "I've really personally tried to come into work knowing that everybody comes from their own experience, and to really try to not take any personal experiences and make generalizations of them." Sarah commented:

> Overall, we do a really good job of trying to be very sensitive and inclusive. I think I try to really, I mean it's hard 'cause we're all human, but try to take out

> any assumptions or personal biases and really get to know the patient and their family, or even coworkers for them instead of whatever perceptions I may have of them before I even getting to know them.

Samantha tried not to let labels placed on patients or their families affect her interactions with them, adding, “When you just take the time to listen to them about how they feel or what they’re experiencing, they’re less frustrated and they’re able to talk to you and they’re not problematic.” She also liked to form her own opinion of patients and maintain professionalism despite how she may be feeling.

> Are they actually problematic or are they just being called that? So I’d just like to see for myself, but even my own emotions, the way I felt like I was trained as a nurse, if someone is saying something to me that makes me feel degraded when I go to the room, I still sit those emotions outside of the door. I know how to turn that off to go in the room because I know what it feels like to be a sick patient. If I’m sick, I don’t want to know about my nurse having a horrible emotional day.

Eileen commented, “In my many years of pediatrics, I’ve always tried not to prejudge people before I meet them, and then to approach them as I was just meeting them, not hearing stuff about them.” Aquarius shared, “I don’t care what color you are, I try to be the nicest or helpful nurse that I can be because I would never want anybody’s experience to be what I’ve experienced.”

Jessica shared a practical strategy she used to avoid mislabeling people by role at work:

> I always look at people’s badges before I ask anything. If you’re dressed in scrubs and I cannot tell, and your badge doesn’t have it on there, I’m like, “Hey, are you the provider? What are you?” And then I let them tell me. I never start with, “Oh, most of the techs here are Black, so you must be the tech,” or, “You must be the sitter,” or whatever.

Theme 11: Communicating Thoughtfully to Build Trust

Nurses in this sample employed several strategies to ensure respectful communication with patients and families and to build trust with patient families who may have had a previous negative experience with their care or with another nurse or clinician. Additionally, nurses emphasized the need to consistently use interpretation services when caring for non–English-speaking families and encourage others to do the same to ensure equitable care was provided. Lastly, nurses identified using inclusive language, including preferred pronouns of the patients, as another strategy to provide patient-family centered care in a culturally sensitive way.

Some nurses worked to build trust with patients and their families. Jen noted:

> I just feel like they don't have a trust with you first because they don't know you. Once you have that, your knowledge and confident that to explain to them what you're going through and then what is the plan. When they got all the explanation that they're looking for, they'd be like, "Oh, you actually know what you are doing."

Aquarius commented, "I try my best to go above and beyond to make all my patients feel comfortable, even their families. Some people, it's not good enough for them. They feel the way they feel."

Nurses coped with the effects of racial microaggressions by learning to trust again. Sheila noted:

> For a while you just kind of watch your back all the time. And I was finding myself, "I can't do that. I can't be in this organization and all this mixed races of people and carry this." At some point you have to trust again, not that you can't always watch your back, but you got to trust again.

Jessica shared one strategy that helped her empathize with patients and families, which was seeing your family in the patient.

> That goes back to how you're raised. When you're seeing this person, do you see your sister or do you see—when I'm with these parents and they're yelling and they're cursing, or with a dad that's yelling or cursing, I see my dad who is upset, or I see my husband.

Likewise, Nicole observed that clinicians who have children of their own "empathize a little bit more 'cause they see their kids in each patient."

Amy shared strategies she used when interviewing or interacting with someone who had a less familiar name: "'I'm sorry, I don't know how to pronounce your name. It's my fault for not knowing. I don't know, but I'm happy to be educated.' But I do absolutely worry about that." Similarly, Aquarius noted, "It's kind of like how I try my best to get people's names right. Because I hate for somebody to pronounce my name wrong. I try to go out my way to, 'So, how do you pronounce your name?'"

Hannah noted,

> I'm also curious what makes a person who they are, or if they have an accent, or curious what brought them here, or where their accent's from and I think as long as it's from a place of curiosity, and wanting to learn, versus pinpointing you are not American, or you don't look like you're American.

A strategy Jessica used was code switching.

> It's almost like to make people comfortable because I do talk a different way when I'm with my Black friends versus with my White friends. I think I'm a product of my environment. I went to predominantly White institutions from kindergarten to college. Even that too, how you're talking, you can be judged for that as well.

Palmer recognized the importance of addressing patients using their preferred pronouns.

> It's such a small thing for me. And then it's so respectful to them. Just try to get that part right. If that's what they're asking, try to get that part right. And don't say like, "Oh, I don't agree with that," or something. It means so much more to them to be respectful of where they're coming from.

Nurses in this study were emphatic about consistently using interpretation services, whether in person or video, to communicate with patients and their families and felt angry when they observed coworkers speaking English to families whose primary language is not English. Rachel observed,

> There are some instances where some providers will be communicating in some ways in Spanish that I don't think it's appropriate for them to be communicating about that topic. I think that that's a disservice to their patients, and it's inappropriate. I've seen people try to explain procedures in Spanish or consent, and it's just not the right thing to do.
>
> If you can understand what they're going to tell you they need, that's one thing as a way to build rapport and trust versus literally speaking to them about their medical condition or their plan of care medically. Sometimes people just speak to them in English. I mean this is a microaggression to patients. But when you get on report like, "The mom understands English, but can't really speak it," that's more than a microaggression. I always then use the interpreter, and you can tell they didn't understand anything, but sometimes people just speak to them in English. People have been speaking to them in English for days, and you just nod. That's a cultural misalignment because a lot of people who are here maybe as undocumented immigrants are seeing us as having more power. They'll just kind of nod along. That doesn't mean they understand.

Theme 12: Doing More To Be Perceived the Same

Nurses of color felt that they had to prove themselves to be perceived as equal to their White coworkers and used multiple strategies to do that. To combat the perception that Black people are always late was motivation for Sheila to ensure she was on time, as she did not feel it was a perception she wanted people to have of her. When a leader tried to sabotage her, Sheila was motivated "to show her that I could get the project done without her," which included going above that leader for information needed to complete the project. After experiencing racial microaggressions from a leader, Sheila reflected,

> But I think the biggest thing is that you just have to say within yourself, "You're going to fight for who you are." It doesn't matter what color I am. I have every right to opportunities than the next person.

During orientation in a new department, Brittany told herself,

> I did not come here for you [manager]. I came here for my patient. I came here to work. I know myself. I am educated person. I know my job. I love this job. That's why I joined this [department]. I just want to prove myself that I am capable to do this work.

Aquarius felt that "as a Black nurse, you feel like you're always trying to prove yourself. I got this. It's very annoying because we've all done the same thing. Everybody who's a nurse passed NCLEX [National Council Licensure Examination]." Being repeatedly questioned by families about her experience made her consider quitting, even though she loved the hospital and didn't want to leave.

> When I was about to quit, I was just so overwhelmed. I was so depressed. I know new nurses experience all of this too. But, I just felt an extra level of unnecessary stress because I just didn't feel supported.

Because many assumptions are made about race, Jessica noted,

> I think that's why, throughout my life I've always pushed to be known by people and be the best. I think I'm just, I'm A type, that's how I was raised. You have to work twice as hard so I think I do that here. But when I first got here, I was in everything and doing everything because I was just, in the beginning, so hurt by, why do they just assume? Is it DC? What's going on? Because I came from [other organization] where it wasn't like that, or I didn't perceive it to be like that. I'm like, "Okay, I need to work so that people know who I am," which is not ... I don't know, I guess it worked for me, but it shouldn't have to be like that.

Additional Findings

After participants answered questions on their experiences as the recipient, bystander, and source of racial microaggressions, questions on racial slights, typical source, impact on patient care, and the impact of microaggressions on nurses were asked to deepen understanding of racial microaggressions in this nurse population. Data are presented below based on the question.

Genesis of Racial Slights

Nurses listed several factors that may contribute to racial slights. These included upbringing, lack of awareness or ignorance of other cultures, people making a joke, habit, bias based on how they were raised, their exposure to date, and disrespect. White people and older people have been identified as frequent sources of racial microaggressions. With some in the older generation, Sarah reflected,

> I think they just were never told that it was wrong. And a lot of it honestly did surprise me because some of these people are from pretty urban areas with a lot of diversity, so you would think that it'd be a little less prominent in their brains, but I think a lot of it is habit.

Rachel felt the cause of slights could be power, dominance, or superiority: "It's definitely a way that people who are in a cultural dominant group feel comfortable asking invasive questions of a person of color and questioning somebody's authority."

When microaggressions are made, it causes you to reflect on your background and race and even question yourself: "You also have to think about your own culture and where you come from and what you learned." At times, "you feel a little intimidated because you're feeling like, 'Where did she get that from? Is she right? Do I need to go back and learn my own history?'"

Brittany mentioned a possible cause of slights to be disrespect and lack of repercussions, noting, "If you don't talk much and if they try to maybe do something and you don't reply or respond to their action, the more that they think they can do something to you." She has experienced that "they can say anything. Because we are Asian, we don't reply back."

Sam felt there were multiple causes, including lack of awareness and consequences and learned behavior:

> Sometimes I think it's their way of finding out about other people in a way, in their own weird way, for lack of a better word. I think other times people realize that they can say this and not be considered racist. But then I think a lot of it is experience, and that's probably what they've been around or they've heard and experienced or were taught and they just go with it without really stopping to question it.

Upbringing can be a cause of racial slights, as people become accustomed to saying things and "they don't think anything's wrong because they haven't had to experience some of these things." People growing up in smaller towns or less diverse areas may do what they've been taught or have seen. Other times, people may commit a racial microaggression when in a safe space "where they're just messing around with each other." One nurse commented, "It's people not really knowing better, or not understanding that could be offensive, or that could hurt someone's feelings." Likewise, "I think a lot of it is just lacking the ability to put yourself in that person's shoes, and once you're able to relate to them I think a lot of them kind of solve themselves." Sheila reflected, "I think it's how you grew up, and things have changed. Things have changed a lot. And I think here in the workplace, we can be a melting pot all we want, but we still have a lot of classism issues and racism issues."

Biases, whether conscious or unconscious, can manifest. Samantha shared,

> People come in from the way that they were raised or things that they've experienced or what they see even in the hospital and they just have these beliefs and they then project them onto other people versus just getting to know the person themselves outside of what it is you think about them before you meet them and talk to them. So I definitely think that it's things that you just bring in with you.

Likewise, Eileen believed “people just need to understand where others are coming from” and we have to consider our unconscious bias. In general, Eileen felt society is a little more entitled and more focused on what they deserve and “and they’re not aware of how they’re interacting with other people.” She identified this similarity in the workplace: “If everything’s going well for them and they’re getting what they want, then why question anything else that’s happening, even though it may not be exactly healthy or a good environment?”

Systemically, this is steeped in American history, which can still be seen in cities with segregation between affluent White areas and poor Black neighborhoods, and racial comments are “just the remnants of a really bad past.” Jen felt that the United States includes a mixture of many cultures and “people have their own background and then when they come together it’s just hard and then that’s why you assume everything.”

The cumulative effect of racial microaggressions is destructive, no matter the cause. According to Elsbeth, “It’s lots of jokes that kind of add up, and you’re like, ‘Okay, what do people think of me? Or do they think I don’t deserve to be here or what?’” As a pediatric nurse, Sam was concerned that these ideas would perpetuate hate: “It sucks, because when you’re doing this, especially in front of kids, kids learn from what they see and it’s just like, we’re just going to keep perpetuating the same ideas.”

Who Are the Microaggressors?

Anyone can be a microaggressor. Based on their experience, nurses in this study identified the following as people committing racial microaggressions: people in the majority race, leaders, patients and their families, coworkers, women, the older

generation, everybody, nurses, patient care technicians, and people when they hear your accent.

Katherine reflected,

> It's something that is so small that you don't think would hurt somebody. And you might not even realize it, like me, how I'm having a realization today. You don't realize it until much later; we're probably all guilty of them, but in the situations that I've brought up, it's been nurses.

Nurses in this sample perceived an age component of both junior and more experienced staff members committing microaggressions. Nicole said of junior staff, "I think sometimes the residents can be, and even within nursing, I think a lot of nursing has been, and myself included, grew up somewhat sheltered, and just never really took the time to think about how much these microaggressions occur in day-to-day life." She also noticed that "there's a lot of nurses, physicians, respiratory therapists alike that as they are older and they have young kids, they start to empathize a little bit more 'cause they see their kids in each patient." On the other hand, one nurse noted this generational difference:

> They're [older generation] not as self-aware about the things that they do that can impact our generation of people, because our generation of people are just more aware of all these microaggressions and that it can be hurtful to some people.

Sheila wondered if microaggressions are committed by "folks who just don't feel like they have self-worth or value, whether that's because of how they've been treated or because of the opportunities that they weren't given."

Impact of Racial Microaggressions on Patient Care

Nurses in this study were asked about the perceived impact of racial microaggression on patient care. Responses varied from no impact to potential impact, as

they have lost trust in a coworker who has committed microaggressions, to improved patient care. Equity in providing patient care and the concept of a very important patient (VIP) were also mentioned. There are many disparities that can affect patient care with organizational data to support that "patients of color are offered telehealth much less than Caucasian people." A few nurses identified that there should be equity in resources provided to patients, with Sheila commenting,

> There should not be a VIP family. Why do we even have that here? Everybody should be treated like a VIP. I mean, there are some folks with status. I get that. But we need to have that attitude toward all our patients.

Scott was able to separate interactions between coworkers and patients, deeming that he would not change the way he treated or cared for a patient, "so I can't say that microaggressions would change anything to do with my patient care, because I have my own standard and I'm going to keep to it." Another nurse shared, "I don't think it will affect me because I treat all the patients equally." Brittany noted,

> I came here for the patient. The patient needs me at the time. It's like they're depending on me. So I have to do my work. I might be hurt inside [following a microaggression] but I have other patients, other families that depends on me. That's how I always think of, that's why every time I go to work I focus myself to the patient and families.

Sam shared, "I think especially because we work in peds, it's really the patient comes first. I can put everything else aside." Similarly, Aquarius would maintain professionalism despite how she was treated: "They're kids, at the end of the day. Because, your mom wants to... Whatever her beliefs are, I'm never going to treat a child wrong, ever. I just can't see myself doing that. It doesn't impact any level of care for me." Eileen identified that racial microaggressions had not impacted the patient care she

provided, “but I think it’s had an impact on my work environment and how I feel about that.”

Conversely, Amy thought less of her colleagues who commit microaggressions, which could impact team performance. “So it’s not towards the patients, but it makes me feel like there’s members on my team that I don’t respect after hearing them say things like that.” Further,

> If there’s a colleague you don’t respect or that you don’t want to be around, it can impact patient care. I mean, they can pick up on that at a micro level, in a sort of subtle way, that you’re not a high-functioning team.

Some nurses noted that their care may be improved, as they were cognizant of the impact of microaggressions on patient care. For example, Chris noted that he was more sensitive to it, asked more questions and listened, but “I try and understand a little bit more where they’re coming from and see if there’s a way that I can find something in common or a way to relate to somebody.” Similarly, Samantha searched for unmet needs with patient families labeled as problematic:

> I’m going in now with my eyes open of maybe there’s a need that this family isn’t getting met, maybe there’s something that they need someone to listen to or hear. So I think that I end up giving better care to my patients because I now feel like I need to be that person to go in and actually try to support them differently.

While she felt this strategy may be beneficial, she worried that a nurse with a different mindset may not provide the best care.

Impact of Microaggressions on Recipient

Nurses were deeply affected by racial microaggressions and often questioned themselves afterward. Long-term trauma from microaggressions caused Brittany to be afraid of making mistakes and made her lose confidence in skills:

> I have to forgive. But it's really hard to forget.... I think I almost lost, even with my previous job, I said, "Am I so dumb?" Every time I talk to her [manager], I felt so dumb. Am I? It's like I don't know anything. It almost like it's my loss of confidence to myself. I felt like it's always mistakes that I'm doing. There's nothing good that I'm doing.

Eileen became upset and tearful during the interview, sharing, "at times, I feel uncomfortable at work. It can be emotional when you realize that your interactions with people aren't taken the same way, or even if certain people, you're just not included."

Jessica noted the long-term consequences of racial microaggressions:

> It's a one-second thing, but it's going to affect you for a long time. I think it'd be good to see how something's so small or minute that you might not even notice, someone's going to carry that with them for a long time.

Rachel acknowledged the impact of racial microaggressions on herself and her coworkers:

> I think that I don't feel that way at work [feeling unsafe with their coworkers and in their environment] because I acknowledge my positionality and my own privilege, but I definitely think that some of my coworkers feel that way. I just see them go to work, and they know it's going to be a bad day. They know people are going to treat them like shit, and that's really bad to see.

A few Black nurses in this sample attended predominantly White institutions and did not regularly experience racial microaggressions. This may have made dealing with workplace racial microaggressions more challenging given their limited experience. Sheila felt:

> Pretty blessed to just not have to deal with a whole lot of that and a few times that I have, I'm just glad I learned from it. Maybe it's good that I couldn't remember some of those moments that didn't impact me in such a way that it caused me to not thrive. Maybe I had many more, but I just didn't recognize it. And I think that's a good thing because I didn't have to address it or harp on it. And I am thankful that I've been sheltered from a lot of it, but my heart does go out to people who experience it a whole lot more than we think.

Nurses shared profound reflections on their experiences with racial microaggressions and how things have changed over time. Of her experience Rachel commented,

> I think that you can say things that are racial microaggressions that also can be not taken as aggression, microaggressions, but I don't know because I guess you're not the other person, so you don't know how they take it. But I feel like I've said to people like, "I like how your hair looks. Did you get it done differently?" I've said things like that. I would feel comfortable telling a White coworker, "I like your haircut," because I noticed they got a haircut. I think that's different from being like, "Your braids are so pretty. Can I touch them?" It's definitely different. But I definitely understand that also there's always ways that we can microaggress people that we don't know. I definitely think that that would be an instance that I know some people are very triggered by that. So that's something I've done, but I've never received feedback that that's inappropriate or nonverbal feedback and body language feedback. But maybe it really does affect people, and maybe it does trigger them inside when other people have done it in an offensive way. Maybe it's upsetting. But I don't know because I'm not living their experience.

Eileen felt saddened by recent events she'd experienced at work:

> It's disappointing. It is very much disappointing. And because I'm someone who thinks that people should treat everyone equally the same and not have any regard out of their background, where they come from. Like I mentioned before, I don't believe it's intentional, but it's definitely there. The level of comfort people have with one another versus other people they may not understand as well, but it is disappointing because I've been in the workforce for many, many years now, and I feel like only recently have I observed it and felt it, other than earlier in my career, and I don't know why that is. I don't know if it's our society or the way culture is these days. Maybe it's the heightened sensitivity people have to race these days, but I did not feel that before, earlier in my career.

Rachel summarized her experience with racial microaggressions in this way:

> I feel like everybody is microaggressing everybody. I feel like it's on all different levels. I feel like it's on the level of administration and management. It's on the level of coworkers. It's on the level of patients and families. I think it's all interwoven. It's an interaction. There's symbiosis. Because if you get labeled as a nurse who's rude to patients and families because you're, again, giving back that energy that you're receiving, then your White coworkers, they feel legitimized in feeling like you're giving substandard care because you're rude.

Despite the various racial microaggressions nurses experienced, Elsbeth noted some improvement in interactions over the past few years.

> Honestly, I think that in the workplace, people are, especially after summer of 2020, people are a lot more cognizant of things. So in the last year or two, even if people are thinking things, they're very careful about what they say. So if anything, it's trended in the opposite direction, where people are maybe even more endearing or mindful of including you and respecting you.

She also commented optimistically, "I think that it's a topic, I think 6 years ago, the word microaggression, I wouldn't have even had any idea what was being referred to. And it's heartening that these discussions are being had more and more."

Training Implications

All employees in the study organization completed an e-learning module on DEI as part of required annual training. One of the more junior nurses in the sample had participated in several simulations in school involving different cultural backgrounds and LGBTQ and remembered that patients "are coming to you for help, so the last thing they need to do is feel judged or discriminated against if you are that provider role." She felt that understanding other cultures led to better patient relationships and helped her subsequently know her place and boundaries.

For Sarah, growing up in a household with immigrant parents helped her recognize racial microaggressions. Since not everyone has that same exposure, she felt DEI trainings "do use good examples for people that might not have recognized that growing up." Additionally, she attributed being able to recognize racial microaggressions to her life experience:

> The family I grew up in and just having to respond to things like that in the past or watching friends and family respond to things in the past, you form that kind of

> sense very young. I think it did help in a way to be able to tell people, "Hey, that's not a cool thing to say," in terms of maybe I wasn't on the receiving end, but just you recognize it more. So, maybe not how to approach the situation of telling someone it's wrong, but more to recognize it and be able to just flag it for others.
>
> As a Black woman, Samantha has experienced this her entire life.
>
> I don't know that the trainings helped me to recognize it more. I think I'm used to it. It is a norm and it is something that I probably turn a blinder onto so that I can continue the work in this setting.

Many nurses did not remember completing the online module or if they did, did not find it helpful in increasing awareness or their ability to respond to microaggressions. The consensus from nurses in this study was that given the nature of microaggressions and DEI topics,

e-learning modules may be less useful. "You're just trying to get through them, just clicking, clicking away." Another noted modules should be succinct: "I feel like honestly, those trainings do become more of a hassle than a benefit, which I think they could be" and that the goal is to "finish it and check the box and move on to the next one." Lastly, one nurse felt that DEI modules "don't make us uncomfortable enough."

Some nurses of color felt that DEI trainings didn't teach them anything they didn't already know from their own personal experience, although there may have been increased awareness of microaggressions that occur. One nurse felt DEI training reinforced the need to recognize and avoid prejudgment of patient families and coworkers. Other nurses learned to seek to understand before making assumptions and to respect people of other cultures, "to not assume people, what they are. You have to be open-minded. Open. Talk to the people first." One nurse of color learned to listen to other people and felt her participation on a DEI committee has given her "so much more

courage now to speak up." However, Scott felt that these types of trainings can "definitely be positive for people who aren't aware about these things, who don't get to talk about it as much, and who don't get to talk about it with POCs." Scenarios included in DEI training can help people identify things they may not have considered a microaggression: "Oh, I didn't realize that's already part of being a microaggression." On the other hand, Eileen reflected, "it's disappointing…. I know it's a difficult topic and it's not always a happy topic, but I don't know how much you can really educate people who don't even realize that they need to be educated."

Eileen felt participating in DEI training helped her respond to racial microaggressions when advocating for a family who declined use of an interpreter. "I don't think I would've said that before and just kept it in. So my ability in that moment in time not to react emotionally because it was a professional issue helped me out." On the other hand, Aquarius noted, "Just me, it won't sit well. I'm going to say something."

Sam thought the most recently offered DEI training was "a really great training" and facilitated meaningful conversations. This type of training was helpful to her to increase awareness, recognition, and to think before speaking but also

> to think about if you could be saying something that could offend somebody else or really stopping to really think about your own behavior and seeing, okay, "Well, if this has happened to me, have I done this to anybody else?"

She also learned to interrupt the behavior of patient families using phrases like, "This is inappropriate behavior at this time."

Training Recommendations

One of the nurses in this study referred to a DEI session that had been facilitated by her supervisor, whom she felt was not trained to lead that type of discussion. “When people aren’t free to speak, I don’t speak freely that often when someone who’s, I don’t know, has a supervisor role is around, it’s uncomfortable.” As a result, Eileen recommended DEI training be facilitated by a consultant or impartial external trainer in a safe space without direct supervisors present, adding it would be better to attend by yourself or with employees from other departments “so you can feel like you could speak up and speak freely without impacting your day-to-day.”

Sam suggested that a refresher of the most recent DEI training would be helpful. Another felt that DEI training was helpful to set aside your own biases, acknowledging that “to step in, or to advocate on your coworker’s behalf, or another family’s behalf, if someone’s making a comment, that would be uncomfortable.” Chris shared that DEI training should provide staff with tools on how to handle conversations in a tactful and polite way. Training increased awareness of comments that nurses had not previously considered to be microaggressions; subsequently “it’s made me a little bit more attuned to it. And then make sure that I’m not doing those.” Amy mentioned that requiring training demonstrates the organization’s commitment to caring, but worried that there may be backlash to the “woke culture.” Aquarius suggested that DEI training be interactive and include case studies or use simulation to improve recognition of microaggressions for staff who may not experience them. Jessica suggested having patient families share their accounts and including role-playing videos. She also proposed

that training may be effective in "recognizing your subconscious bias while you're trying to deescalate someone. That's hard because emotions are high."

Open dialogue that happens during DEI training can promote discussion between people of color and White people as well as across generations. Two nurses had been involved in hospital-wide or unit-based DEI workgroups focused on language equity and advocated daily based on awareness of initiatives. Sheila recommended continued exposure with DEI training:

> We have to start threading in things, making those things a part of the real culture if we want people to continue with those behaviors. And I think we do these classes and then we just kind of let people go.

Having participated in a virtual DEI dialogue in 2020 using breakout rooms, Samantha was able to share her personal experience with others:

> Had you ever experienced anything racially driven at the hospital? And most of them all said, "No, it was perfectly fine. Everyone treats everyone fair." And I was like, "Actually, no, I don't think so. I've experienced this or that." And they were just in such shock like, "Oh my gosh, I had no idea that these types of things were happening." I don't know if they walked away from that and did anything with it, but I think it was jaw dropping or eye opening to them to actually hear an experience versus doing a standardized module.

Through participating in DEI training, Sheila acknowledged

> just how much work we have to do. I mean, I'm not being negative. I'm trying to be optimistic, but it was such an eye-opener still how much more work we have to do. We've come a long way. But we still have a lot more work to do.

Impact on Organizational Culture

Some nurses felt that DEI training has the potential to positively impact organizational culture for all who participate. Nicole felt "just the importance of acknowledging that these trends do exist, whether we want them to or not.

Acknowledging and owning up to them is a key point to addressing and coming towards a solution." Sam noted that training "starts these conversations and gives people a space to open up and talk or to share concerns." Meanwhile Samantha was hopeful that DEI training could improve organizational culture, but doubtful "based upon the fact that these things are still happening."

Chris felt if done right, DEI training could impact organizational culture:

> The best ones are conversations but with people who are specially trained to handle those conversations, not necessarily leaders that are working within the hospital. Some may be qualified to do so but sometimes it's nice to have an impartial person come in and have those tough conversations. But also manage them to say, "that's not appropriate to say here." And kind of steer the conversation into a respectful and polite way instead of some people doing it in the wrong way, in which case resentment comes out and I think has the reverse effect of not creating barriers where they didn't or were not as defined before.

Eileen recognized that education is offered and "it's talked about, but I haven't really seen any great impact about that or any true mission to improve that." Additionally, Aquarius noticed the lack of diversity in leadership, adding "not just having Black people, but more women."

Comments on Organizational DEI Policies

Nurses had varying awareness of organizational DEI policies and procedures. Several were unaware that such policies existed, and if there were policies, felt that they hadn't seen anything being done to address microaggressions. For example, one nurse commented on a unit leader who "commits most of the worst microaggressions; the unit kind of knows and they just kind of let it slide because she's been here for forever and there's nothing we can do to get her to stop, basically." In this case, there was fear of speaking up, as "she's the type of person that if she doesn't like you, she'll assign you …

really bad assignments." Another nurse was unaware of policies but thought the hospital "in general is such a diverse and welcoming organization, and I think that you see that when you walk through the halls." Still another nurse felt the current policies were useful, but the implementation could be improved so that all staff have "an equal platform" to share their experiences.

Aquarius felt the organization could be doing a better job in addressing DEI issues.

> I think it's kind of, "Oh, let's just do this just to say that we're doing this." But, they're not really getting to the meat and potatoes of what is really going on within the employees in the hospital. They're trying to do right. But, I don't think that it's really working that well. Because, nothing's really changing.

In her daily work with patient families, Jessica noted that families will say, "They're treating me like this because I'm Black. Sometimes I'm like, 'Okay, you're stretching it. I'm Black too, girl. You're stretching it.' Sometimes it's like, 'Oh my gosh.'" Witnessing these situations firsthand, she can appreciate the fear of speaking up.

> We have to work with these people so it's a fine line. I encourage them to, if they witness it, to file a complaint anonymously. But it's just like there's, no one is held accountable. It's just like, "That's how she is. That's how he is."

A few nurses commented that they felt the organization was trying and has made strides but has a long way to go in addressing microaggressions and other forms of discrimination. "There's always work that can be done," but there was also an acknowledgment that this is a large and broad topic to address. Jessica felt that, "in general, the hospital post 2020 is trying. I don't want to say they're not trying, we have a whole DEI group. I think we have a long way to go."

CHAPTER 5:

SUMMARY, DISCUSSION, AND CONCLUSIONS

Study findings were presented in the previous chapter. This chapter provides a summary of the study, discussion of study findings, implications for nursing practice, implications for nursing education, limitations, recommendations for future research, policy recommendations, and conclusions. The purpose of this chapter is to amplify the research question to provide a further understanding of its possible influence on nursing education, practice, and policy and future research.

Summary of Study Aims

Nearly two-thirds of registered nurses (RNs) in a national survey (N = 5,623) personally experienced racism at work, while more than half felt that racism negatively impacted their professional well-being (National Commission, 2022). While the Future of Nursing calls for increasing the diversity pipeline of RNs (NASEM, 2021), nurses are frequently recipients of microaggressions from both colleagues and leaders, resulting in burnout, negatively impacting well-being, and hindering recruitment and retention efforts (Ehie et al., 2021). It is critical to understand the experience of nurses with racial microaggressions to improve workplace culture. Therefore, this study sought to explore workplace racial microaggression experiences of nurses practicing in an academic children's hospital in the Mid-Atlantic region of the United States.

The microaggressions triangle model depicts human interactions in which individuals can be the recipient, bystander, or source of microaggressions at various

times. This framework was used to guide the study, including data collection and analyses.

This study used a qualitative exploratory design. Individual interviews were conducted with a convenience sample of RNs working at the study site. Nurses employed by the study organization were eligible to participate if they had experienced or witnessed a racial microaggression in the workplace. Eighteen interviews were conducted with nurses between June and August 2023; however, in retrospect, saturation was reached after the 12th interview. Participant demographics were presented in Table 4.1. The study included one research question with three subquestions based on the perspectives of the microaggressions triangle model:

Research question:

What is the experience of racial microaggressions of nurses working in a children's hospital?

Subquestions:

1. What is the experience of racial microaggressions of nurses as a bystander?
2. What is the experience of racial microaggressions of nurses as a recipient?
3. What is the experience of racial microaggressions of nurses as the source?

Thematic analysis was conducted using Braun and Clarke's (2006) six-phase approach. Based on results, study aims were met.

Discussion of the Findings

Based on the model constructs, the microaggression perspectives of recipient, bystander, and source were collected. Of these three perspectives, three categories emerged on experiencing, responding to, and addressing racial microaggressions. The

first category, “Experiencing racial microaggressions,” included themes of (*1) biased first impressions, (2) “firing” the nurse, (3) questioning experience or credentials, (4) where do I belong?* and (5*) all jokes have a grain of truth.* The second category, “Responding to microaggressions” contained the themes *(6) not being silent, (7) intentional nonconfrontation,* and *(8) showing or seeking support*. The third category, “Addressing microaggressions using personal and professional strategies,” included the themes *(9) empowering, (10) bracketing, (11) communicating thoughtfully to build trust,* and *(12) doing more to be perceived the same*. Nurses personally experienced, observed, or committed racial microaggressions, aligning with the perspectives of the microaggressions triangle model. Further, nurses experienced racial microaggressions in the three forms described by Sue et al. (2007): (1) microinvalidations, (2) microassaults, and (3) microinsults.

All nurses in this study witnessed racial microaggressions in the workplace, with most having personally experienced them and most admitting to being the source of a microaggression at some point. Some nurses shared they were careful to avoid committing racial microaggressions since they were aware of how they personally felt as a frequent recipient of them.

Nurses recounted responding to racial microaggressions as a recipient, bystander, and source, supporting the standpoints identified in the microaggressions triangle model. Overall, nurses were more likely to respond to racial microaggressions as a bystander compared with as a recipient, as the recipient may not feel comfortable speaking up for a variety of reasons. As a recipient of racial microaggressions, nurses responded in various ways, including avoiding conflict and giving people a pass, but they also spoke up to

address the comment, educate, or correct an assumption, and they used humor and proved themselves by working harder. At times nurses responded to microaggressions but requested additional training on how to best reply. Upon realizing they were the source of a racial microaggression, nurses responded by apologizing, reflecting, and seeking to learn from the experience.

Lastly, nurses shared recommendations for future training that included using simulation and role play, sharing first-person accounts, increasing discomfort of attendees to make the message clear, promoting open discussions, and using impartial external trainers to facilitate sessions. Regarding organizational policies and procedures, nurses had varying awareness of existing policies, noted speaking up or fear of speaking up as a challenge, and some lacked trust in the system. The impact of racial microaggressions experienced by nurses in this sample caused physical and emotional distress and long-term consequences and trauma.

The results of this study were consistent with previous studies on racial microaggressions of nurses. Nurses in this study experienced feelings of frustration, disbelief, self-doubt, and reflection when faced with workplace racial microaggressions and felt the need to prove competency and their credentials. These findings align with previous studies of nurses of color with bias and discrimination (Cottingham et al., 2018; Moceri, 2014; Wilson, 2007; Wolf et al., 2023). Nurses of color acknowledged that coworkers spoke to them differently based on their race, which was described by Cottingham et al. The theme of connecting with patients identified by Black nurses encompassed caring, advocacy, teaching, and respect and communication (Wilson, 2007),

and was like the theme “Communicating thoughtfully to build trust” that emerged in this study.

Nurses in previous studies experienced microaggressions from patients, coworkers, and supervisors and established coping mechanisms to deal with discrimination (Wheeler et al., 2014). Strategies nurses developed included mentoring (Wilson, 2007) and addressing microaggressions with patients and coworkers by correcting assumptions and teaching about racism and discrimination (Wros, 2009). Black nurses were assumed to be other nonclinical roles, like techs or housekeeping, and experienced patients refusing their care based on their color (Wheeler et al., 2014). Inequity from hospital leaders presented as favoritism when nurses of color sought advancement (Wheeler et al., 2014), which was mentioned by a nurse of color in the current study.

The findings of this study supported the perspectives of the microaggressions triangle model, as nurses experienced and responded to racial microaggressions from the perspectives of recipient, bystander, and source. Although the model suggests we can all be on one point of the triangle at different times, a surprising finding was the candor with which nurses in this study owned microaggressions they had committed and remembered them with vivid detail. Unconscious bias may contribute to microaggressions such that the source may be unaware of the impact of their words or actions, and well-meaning people can be the source of a microaggression, causing them to be humiliated or defensive (Ackerman-Barger & Jacobs, 2020). However, in this study nurses shared they apologized to the recipient for the microaggression and viewed it as an opportunity for reflection and personal growth.

The extent to which patients' families, specifically parents, committed microaggressions against RNs was also unexpected. As nurses undoubtedly spend the most time with patients and their families, it seems counterintuitive that parents would mistreat them. However, unconscious bias and lack of awareness could have contributed to the extent to which microaggressions occurred, and some nurses wondered whether these comments came from a place of curiosity or a deeper unconscious intent. The stress of having a child admitted to the hospital, along with loss of control, can also be a possible factor.

Nurses described leaders being the source of racial microaggressions, which is consistent with the *Racism in Nursing* report, where 70% of Black nurses reported experiencing racist acts from leaders (National Commission, 2022). This points to the need for targeted education and workshops for nurse leaders on recognizing and addressing workplace microaggressions, and a need for workplace culture change. Nurse leaders possess the accountability and responsibility to set the tone for their nursing units or departments. Microaggressions training may encourage nurse leaders to reflect on their own unconscious biases, allowing them to put biases aside to promote effective relationships.

All nurses must be equipped to recognize and respond to workplace microaggressions, whether racial or based on age, gender, sexual orientation, religion, or other personal characteristics. Nurses in this sample shared that they found open dialogue a more effective way to learn about microaggressions than traditional e-learning modules, which do not allow for engaging with and learning from coworkers.

Although some nurses recounted sharing accounts of racial microaggressions with their family members (adult daughter, mother, sister), nurses tended to discuss negative interactions with peers after they occurred. This could be due to needing to vent or debrief more immediately to continue their work. One nurse mentioned that she put on "blinders" to continue to work in her practice setting. Absorbing the negative impact of microaggressions can lead to mental and physical health problems (Sue et al., 2007). In this sample, nurses momentarily put aside feelings of being upset or hurt to focus on caring for their patients, who are children.

Some of the racial microaggressions experienced by nurses in this sample were previously reported in the literature. For example, a participant committed a microaggression when commenting that a friend and colleague was "exotic." One category of microaggressions is exoticization and eroticization, which sends a message to people of color that they're different or otherworldly (Sue et al., 2007; Williams et al., 2021). Nurses witnessed the bias of avoiding non–English-speaking families due to time and being asked by patients about their credentials and schooling, similar to that of emergency department nurses in a recent study by Wolf et al. (2023). The same study identified racism and discrimination as threats to safe patient care and nurse well-being. Similarly, nurses in this study identified the impact of racial microaggressions on patient care and teamwork and how they felt in the work environment. Nurses in this study were more likely to speak up as a bystander of a racial microaggression to support a colleague, which differed from the findings shared by Wolf et al. (2023) in which emergency nurses did not intervene when witnessing bias for fear of becoming a target.

Some nurses of color admitted they had been “sheltered” from racial microaggressions, having been educated in primarily White institutions. This seemed to make their experiences with recognizing and responding to microaggressions more challenging given their limited experience with it. They were empathetic to individuals who regularly experienced microaggressions and perceived their experiences as a recipient as learning opportunities. One of the nurses acknowledged that her manager has helped her to respond to microaggressions in a professional way using the phrase, “What did you mean by that?” to explore the intent of the microaggression. All nurses in this sample, regardless of race, experienced racial microaggressions, which is consistent with findings of the survey conducted by the National Commission on Racism in Nursing which noted that Black, Asian, and Hispanic nurses experienced racism more frequently than White nurses (National Commission, 2022).

The memorable nature of racial microaggressions was also an unexpected finding, with several nurses sharing experiences that had occurred 10 years earlier in startling detail, as if the event had occurred recently. This demonstrated the destructive nature and lasting impact of microaggressions on recipients, which has been previously reported (Sue et al., 2007; Williams et al., 2021).

Implications for Nursing Practice

Data from this study indicate there are workflow, workload, and patient care consequences related to experiencing racial microaggressions. When families refuse a nurse due to race or ethnicity, there is a dilemma of how to proceed with patient assignments and staffing for the shift, although there may be a few exceptions when this request is appropriate for cultural reasons (e.g., no male caregivers for a female Muslim

patient). If the assignment is changed, then the family gets what they want, which may perpetuate the discriminatory behavior, as they may continue to treat nurses and other staff members poorly. However, if the assignment remains the same, the nurse may be subjected to mistreatment for the entirety of their shift.

Another scenario identified in this study was assigning Spanish-speaking nurses to Spanish-speaking families. One nurse noted that her coworkers consider this a burden, but this could also be considered a best practice and culturally appropriate care. In a study of Hispanic nurses, they identified an additional burden of translating for patients without recognition for their expertise (Moceri, 2014). The added burden could be felt when translating for the patients of other nurses, but it does seem sensible to assign patients to nurses who can communicate most efficiently with them. There should be a standard organizational approach of how these situations are handled to manage the expectations of patient families and staff members, while simultaneously appreciating diverse workforces and patients and creating a culture of equity and inclusion.

Several Black nurses shared negative experiences during their unit orientation, feeling “nitpicked” compared to their White peers. If the nursing profession is to actualize the goal of building a diverse nursing workforce, then education should include DEI content and hiring practices must support DEI to optimize a culture of inclusivity and belonging. Nursing leaders, including preceptors, should be trained in recognizing and responding to racial microaggressions. Check-ins during orientation with nurse educators may serve to identify any issues early in orientation.

Because this study occurred in an academic children’s hospital in the Mid-Atlantic region of the United States, there are important considerations for this topic in

terms of role modeling appropriate behavior for children, as nurses in the study feared children would perpetuate the discriminatory actions and behavior they observe. Therefore, it is important that nurses speak up when patient families commit microaggressions to identify the behavior and provide a positive example. As most of the nurses in this study noted, patient care was not negatively impacted due to racial microaggressions, and they demonstrated empathy for the children, who were innocent and separate from their parents' biased behavior.

Another practice implication is patient education on expected nondiscriminatory behaviors when seeking healthcare. As this study was conducted in a children's hospital, the patients were children and were typically not the source of microaggressions; rather, they came from their parents or caregivers. Nurses and other healthcare professionals must be supported in not tolerating this abusive behavior when providing care. Further, healthcare organizations must develop and enforce policies and procedures with patients, families, and staff who violate them.

Findings of this study and other studies that show the negative consequences of hospitals with perceived poor work environments, such as burnout and intent to leave, should encourage healthcare organizations to develop and enforce policies aimed at addressing this environment. A recent study by Aiken et al. (2023) found that on average 40% of nurses would leave their current hospital, and that hospitals with negative work culture had considerably more nurses experiencing high burnout, job dissatisfaction, and intent to leave the organization. It is unknown what role microaggressions played in making work environments unfavorable, although it is a modifiable source of stress and burnout that could be addressed within healthcare organizations.

Nurse well-being and recruitment and retention efforts can be negatively impacted by microaggressions and other forms of discrimination. Nurses in this sample shared wanting to quit during orientation and of dissuading other nurses of color from applying to work on their unit because of leaders who targeted nurses of color. Among hospital-based nurses of color, workplace racism contributed to job dissatisfaction and emotional distress (Thomas-Hawkins et al., 2022). These authors recommended a multipronged and strategic approach to decrease workplace racism beyond antiracism training for individual nurses, including training for nurse leaders to engage in crucial conversations with nurses of color and listen to their experiences, as well as hospital-wide policies and procedures that aim to dismantle racism in hospitals. The Future of Nursing advocates for a holistic approach to address nurse well-being, which includes action from individual nurses, schools of nursing, nurse leaders, employers, policy makers, and professional organizations (NASEM, 2021).

Implications for Nursing Education

Some nurses in the sample shared that DEI training was helpful to identify some things they hadn't previously considered microaggressions. If people are not aware of the impact of their words or actions and recipients do not speak up, they will continue to act the same. There is an inherent toxicity in letting a microinsult go because it was a joke or giving people a pass, which can cause "internalized self-harm," as one participant noted. Encouraging a culture of speaking up against microaggressions and equipping nurses with the tools to do so must be a priority in organizations and schools of nursing, but also for the nursing profession. Because speaking up as the recipient can present risk, there is power in bystanders speaking up to address microaggressions. Thus, DEI training can

serve to improve awareness of racial microaggressions and how to respond when they occur in a professional way that invites discussion rather than calling someone out for their behavior.

Nurses in this sample occasionally responded to workplace racial microaggressions but requested additional training on how to best reply. Models like the OWTFD model (Sotto-Santiago et al., 2020) and the acronyms ACTION, ASSIST, and ARISE (Ackerman-Barger & Jacobs, 2020) can be useful to provide scripting for nurses and others to respond to microaggressions. Content on recognizing and responding to racial microaggressions should be incorporated into nursing orientation for all nurses and into nurse residency classes with opportunities for role play and peer coaching on how to respond professionally in various scenarios (e.g., with patient families, coworkers, and leaders as sources).

Systems must be in place to support a culture of inclusion and belonging within healthcare organizations. For example, within the study organization, staff can submit safety event reports on bias events. Nurses need to be educated on how to do so with exposure to reporting systems included in nursing orientation. Staff should be encouraged to submit events using their name versus anonymously to ensure follow up on the incident. Some nurses may be disillusioned by reports submitted anonymously, which do not foster open conversation or resolution about the event, or by lack of leadership support in addressing the issue. Healthcare organizations must take appropriate action following submission of a safety event report, to include patient discharge, banning family members who violated the policy, or warnings for healthcare workers through dismissal based on the offense.

Limitations

One limitation of the study is that it occurred in an academic children's hospital in the Mid-Atlantic region of the United States and findings may not be transferable to other settings. The nursing workforce employed in this organization is more diverse than the nursing profession in the country, with 54% of the nurses being White compared with 80% in the United States (Smiley et al., 2023), which may limit transferability to less diverse organizations. Selection bias is another limitation, and the nurses who participated may have experienced more or less racial microaggressions than other nurses in the organization or may be more attuned to microaggressions occurring. Another is that participants were interviewed by an employee within their organization. However, a few nurses commented that because they knew and trusted the researcher, they felt comfortable sharing their stories and being honest.

Recommendations for Future Research

Many of the published studies on racial microaggressions were conducted with physicians and medical and nursing students, with fewer studies focused on practicing nurses. In the United States, the topic of race and microaggressions has been more prominent in the past few years due to highly publicized unjust and traumatic racially motivated events. As such, there seems to be more open dialogue and focus on this topic. Future studies need to determine the frequency and types of microaggressions nurses experience in a variety of settings and assess their impact on job satisfaction, intent to leave, and quality of patient care delivered. Additionally, research should focus on exploring strategies used by nurses to cope with microaggressions and their efficacy in fostering well-being. The National Commission on Racism in Nursing, in its report

Racism in Nursing, presented results of a national survey of nurses on racism experienced in the workplace and implored all nurses in the United States to challenge racism to improve outcomes for nurses, patients, and society (National Commission, 2022). Studies can also examine microaggression experiences of patients from underrepresented backgrounds, and implications for patient-provider relationships and health outcomes.

There are valid, reliable tools to measure learning from DEI training. However, many of these tools are lengthy and not practical to use with busy clinicians. Future research must focus on validating tools to measure learning from DEI training in schools of nursing or within workplaces. Assessment of learners after DEI training is also lacking. Longitudinal studies must be conducted to evaluate higher levels of learning, including behavior change and impact on patient outcomes. Studies evaluating DEI curricula are often conducted in single sites. Future work should be conducted across multiple schools or healthcare systems to ensure generalizability of results across healthcare settings and regions of the country, which vary in terms of diversity. Research should be conducted to examine the role of organizational culture in perpetuating or lessening microaggressions within healthcare institutions and explore interventions to promote a more inclusive work environment.

DEI curricula should be replicated to identify best practices in nursing education. Lastly, DEI efforts must be hardwired and evaluated using validated measures, just as safety has been hardwired in much of the U.S. healthcare system. Metrics such as program retention, graduation rates, and National Council Licensure Examination rates can be used to measure outcomes for nursing students of color, while outcomes for nurses of color include retention, advanced degrees obtained, and job satisfaction. Schools of

nursing and healthcare organizations may engage in diversity engagement surveys. Opportunities for improvement can be used to implement and study interventions aimed at improving nurse engagement and organizational culture. Additionally, data on microaggressions must be collected and considered in research examining nursing shortages, especially at the bedside.

Policy Recommendations

There are policy implications at organizational, health system, state, and federal levels to address racial microaggressions, and policy-related antecedents that must be considered to ensure successful policy adoption and implementation. Many systemic factors have contributed to longstanding racial inequities and discrimination in the United States, including a national discomfort confronting racism, admitting that healthcare clinicians are part of the problem, a lack of stable political motivation to address inequities, a fragmented healthcare system, and a lack of existing data on health equity (McFarling, 2022).

Organizational culture is a key factor impacting employees' willingness to speak up and report microaggressions, which requires leadership support and encouragement (Zhuo et al., 2021). Some healthcare organizations are deficient in conducting regular assessments of organizational culture related to diversity and equity, while others, despite conducting surveys on the diversity climate, may not be transparent in sharing results with staff (Gilliam & Russell, 2021). Historically, healthcare organizations have adopted a "patient first" stance. This perspective supports patient rights but can have negative impact on employee morale when staff feel disrespected by the patients they serve (Warsame & Hayes, 2019). As a result, there may be numerous policies upholding

patients' rights, but far fewer on how to handle patient and visitor misconduct. Further, when organizations do have these policies in place, often staff are unaware of them, or they remain unenforced.

Healthcare organizations and systems should consider racism as a preventable harm and focus on it like other preventable harms (National Commission, 2022) and implement policies to protect healthcare workers from verbal abuse, including microaggressions. Additionally, there must be clear mechanisms for nurses and other clinicians to report discriminatory behavior from patients and families and consequences when the behavior continues. Organizations may have reporting structures in place (e.g., safety event reports) for staff to report bias events. However, healthcare professionals frequently experiencing discrimination may be unaware of the option to report such events or may fear retribution from those in positions of power, particularly trainees and ancillary workers. Staff may not recognize microaggressions and, therefore, not address biased comments made to them, which leads to continued behavior by the source.

Discriminatory comments made by a person in a position of power may not be addressed for fear of embarrassing them or possible retribution. In addition to recognizing a microaggression as a barrier, the timing of addressing a microaggression is also complex. For example, responding in real time may not feel appropriate in the presence of a patient or family. It may be more appropriate to discuss the situation with a friend or colleague to develop a plan of how to discuss the comment later (Ackerman-Barger & Jacobs, 2020). At the organizational and health system level, nurses and other clinicians must be educated on how to report and encouraged to report. Appropriate follow up on reported events from leaders is essential to reinforce staff reporting.

Many professional nursing and healthcare organizations have published position statements related to diversity, equity, and inclusion in the past few years. Position statements must be followed with policies involving tangible deliverables aimed at minimizing bias to reduce health disparities and improve organizational culture. Next, outcomes must be measured and shared with results tied to organizational incentives to ensure momentum (e.g., U.S. News & World Report) (Rotenstein et al., 2021). Accrediting bodies requiring transparency around DEI culture may generate competition among organizations and attract patients and staff seeking an inclusive environment. Metrics such as nurse satisfaction are currently measured as part of the American Nurses Credentialing Center Magnet Recognition Program® and could be enhanced by DEI efforts. State boards of nursing could mandate DEI training as a licensure requirement, as has been done with other priorities.

Lastly, accrediting agencies, such as The Joint Commission, could require diversity audits to enforce compliance with predetermined diversity metrics. In addition, payers could implement performance-based payment for equitable care, much like what has been done for value-based care and care quality, to ameliorate microaggressions and racism in healthcare. For policies to be successful, funding must be allocated to target identified disparities as national health priorities with a standardized approach and reported metrics to evaluate program effectiveness. At the federal level, funding must be allocated for microaggressions and DEI training for nurses and other healthcare professionals. Research funding is needed to study behavior change and the impact of DEI training on nurse satisfaction, retention, and patient outcomes. In addition, healthcare organizations could be designated as centers of excellence for their efforts in promoting DEI and optimizing nurse and patient outcomes.

Conclusion

This study explored workplace racial microaggression experiences of nurses practicing in an academic children's hospital in the Mid-Atlantic region of the United States. Findings show that RNs experienced and responded to racial microaggressions as a recipient, bystander, and source from coworkers, leaders, and patient families and used various personal and professional strategies to cope with microaggressions.

Nurses openly and honestly shared their workplace racial microaggression experiences, revealing the painful incidents they encountered in both their personal and professional lives. It is well known that nurses have long been the most trusted healthcare professionals. If nurses of color are regularly mistreated at work, then one can only wonder about the experiences of people of color in technical and ancillary roles within healthcare.

The National Commission to Address Racism in Nursing has identified racism in nursing as a significant issue affecting patient safety, nurse well-being, and job performance and has called all nurses to action (National Commission, 2022). Since patient outcomes are improved when nurses look like them, it is essential to create a diverse nursing workforce. Efforts must be made to recruit and retain diverse nurses, and schools of nursing and healthcare organizations play a critical role in implementing structures upon which to build a culture of inclusion and belonging. A priority area for academic and practice-based nursing educators must be to equip nurses and nurse leaders with the tools to recognize and respond to workplace racial microaggressions. Ensuring equity and inclusion is a mandate for the health and well-being of nursing as a profession.

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APPENDIX A:

INFORMED CONSENT FORM

Informed Consent Form
The Experience with Racial Microaggressions of Registered Nurses Working in a Children's Hospital
IRB # NCR234742

Principal Investigator: Richard Ricciardi, Ph.D., CRNP, FAANP, FAAN
Sponsor: The George Washington University School of Nursing

Key Information

You are invited to participate in a research study under the direction of Dr. Richard Ricciardi of the Department of Nursing, George Washington University (GWU). The research is partially funded by The George Washington University School of Nursing. Taking part in this research is entirely voluntary. Further information regarding this study may be obtained by contacting Heather Walsh, doctoral student researcher, at 202-476-4202 or hwalsh@childrensnational.org.

The purpose of this study is to describe the experience with racial microaggressions of RNs working in a children's hospital. Participation in this research involves participating in one virtual or in-person 20- to 60-minute interview. The reasons you might choose to volunteer for this study include adding to the knowledge base about racial microaggressions in nursing and identifying strategies to create a culture of equity and inclusion within the organization and the nursing profession. The reasons you might not choose to volunteer for this study include possibly becoming emotional in recounting personal experiences of racial microaggressions or witnessing racial microaggressions.

You are being asked if you want to take part in this study because you are a registered nurse (RN) at Children's National. Please read this form and ask us any questions that will help you decide if you want to be in the study. Taking part is completely voluntary and even if you decide you want to, you can withdraw from the study at any time.

Your employment status will not be affected in any way should you choose not to take part or to withdraw at any time.

Children's National registered nurses who experienced the phenomenon of interest (experienced or witnessed racial microaggressions in the workplace) are eligible to participate.

The total amount of time you will spend in this study is estimated to be one hour over the course of the next six months. If you choose to take part in this research, you will participate in a virtual individual interview by a study team member, which is expected to

take no more than one hour. You may be contacted after the interview and asked to review whether the explicated themes resemble your described shared experiences.

Minimal risks to participate in this study are anticipated. You are free to skip any questions. If you feel the need to talk to someone about the emotions you are feeling, you will be provided with information on how to access the organization's employee assistance program.

There is a small chance that someone not on our research team could find out that you took part in the study or somehow connect your name with the information we collect about you; however, the following steps are being taken to reduce this risk: the research team will not share names of nurses who participate with others to maintain your confidentiality, transcripts of interviews will be deidentified, and the personally identifiable information collected will be coded using a fake name (pseudonym). The coded lists are only accessible to the research team. The information that has your personally identifiable information will be kept separately from the rest of your data. The audio files and transcripts will not be labeled with identifiers and only pseudonyms will be used.

The records of this study will be kept private. In any published articles or presentations, we will not include any information that will make it possible to identify you as a participant and will use your chosen pseudonym. The only time identifiable information (email address) will be directly linked to your responses is when the research team emails you a copy of the deidentified transcript for review of its accuracy.

Talk to the research team if you have questions, concerns, complaints, or think you have been harmed. You can contact the Principal Investigator listed on the front of this form at 202-994-1494. For questions regarding your rights as a participant in human research, call the GWU Office of Human Research at 202-994-2715.

APPENDIX B:

RECRUITMENT FLYER

Seeking ALL Children's National Nurses!

Are you interested in participating in a research study to discuss your experience with racial microaggressions* in the workplace?

As part of doctoral studies, Heather Walsh is conducting a research study on RNs' experience with racial microaggressions in the workplace.

The study will take place via Zoom or in person and is expected to take 20-60 minutes to complete. Participation is voluntary and all efforts will be made to maintain confidentiality. Children's National RNs are eligible to participate if you have experienced or witnessed racial microaggressions in the workplace.

- *Findings from this study may inform future diversity, equity, inclusion training at Children's National.*
- *Participation in nursing research can be submitted for Clinical Advancement Program (CAP) points.*

If you are interested in participating and sharing your experience about racial microaggressions or have questions about the study, please contact Heather Walsh at hwalsh@childrensnational.org or 202-476-4202.

* Racial microaggressions are defined as brief and commonplace daily verbal, behavioral, or environmental indignities that communicate negative racial slights towards people of color (Sue, 2010).

APPENDIX C:

INTERVIEW GUIDE

The Experience with Racial Microaggressions of Registered Nurses working in a Children's Hospital

Thanks for agreeing to participate in this study. The purpose of this study is to contribute to nursing knowledge about the experience of RNs with racial microaggressions in the workplace. Participation in the study is voluntary, and you may choose to withdraw from the study at any time and with no consequence on your role as an employee. I will be asking you questions about your experience and will audio tape our conversation and take notes as you answer the questions.

1. Have you reviewed the study information sheet? Yes/No
2. Do you have any questions about what is explained in the information sheet? Yes/No
3. Do you have any questions before we begin? Yes/No

By responding to the following questions, you agree to participate in this study.
Before we begin with the interview, I will ask you several <u>demographic questions</u>.

Question	Answers
How do you identify ethnically? How do you identify racially?	- White / Caucasian - Asian-Eastern - Asian-Indian - Hispanic - Black/ African American - Native-American - Mixed race/ Multiracial - Other: - I prefer not to say
What is your gender identity?	- Female - Male - Non-binary - Trans-man - Trans-woman - Other (specify if comfortable): - Prefer not to answer
What is your country of origin?	
Would you describe your birthplace as rural, suburban, or urban?	- Rural - Suburban - Urban
How old are you?	

Question	Answers
What is your highest level of education?	- BSN - MSN or Masters - DNP, PhD - Other:
How many years have you been a nurse?	
How long have you been at Children's?	
What is your area of work: inpatient or outpatient?	- Inpatient - Outpatient - Other: _____
To protect your confidentiality, what pseudonym would you like to use? This is a unique name to protect your identity; we will use this name on your transcription files.	

Interview Questions

To ensure we're on the same page, racial microaggressions are defined as brief and commonplace daily verbal, behavioral, or environmental indignities that communicate negative racial slights towards people of color (Sue, 2010).

- Have you ***witnessed*** any racial microaggressions in your workplace in your role as a registered nurse?
  a. Can you tell me about what happened?
  b. Describe the feelings you had as a bystander witnessing a microaggression.
  c. What did you do to cope with these feelings?
  d. Did you respond to the microaggression as an observer or bystander? If yes, how? If no, what prevented you?

- Have you ***experienced*** any racial microaggressions in your workplace as a registered nurse?
  a. Can you tell me about what happened?
  b. Describe the feelings you had as the recipient of a microaggression.
  c. What did you do to cope with these feelings?
  d. How did you respond to the microaggression? Did you?

Now that you've talked about your experience observing and witnessing racial microaggressions, I'm going to ask you to reflect on a time when you may have been the source of a racial microaggression.

- Please tell me about a time when you may have been the ***source*** of a racial microaggression.
  a. Can you tell me about what happened?
  b. Describe the feelings you had as the source of a microaggression.
  c. How did you respond when you recognized you committed a microaggression? Did you?

- What do you think was the cause of these racial slights, either witnessed, personally experienced, or where you may have been the source?
- What impact have racial microaggression(s) had on your ability to provide quality patient care?
- In your experience, who tends to be the source of racial microaggressions? Please avoid using specific names, but you can describe their role.
- What are your thoughts about the organization's policies and procedures to address racial microaggressions?
- How have your years of nursing experience impacted you in dealing with microaggressions?

Now I'd like to talk a little bit about training.

- Have you participated in any diversity, equity, inclusion (DEI) or microaggressions training? Y/N
  - If YES, continue
  - If NO, skip to next question

  a. If so, what was it (e-learning modules, in-person or synchronous session)?
     _____
  b. Did you attend DEI or microaggression training as a nursing student or as a registered nurse? Student/ RN
  c. What did you learn that was helpful to you?
  d. How did training impact your ability to recognize racial microaggressions?
  e. How did training impact your ability to respond to racial microaggressions?
  f. How did the training change your ability to recognize how others experience racial microaggressions?
  g. Do you believe that DEI trainings have a positive impact on the culture of your organization?
  h. Have you changed the way you interact with patients?
  i. Have you changed the way you interact with peers?
  j. Have you changed the way you interact with leaders?
  k. After the training, are you confident you have the skills to respond to microaggressions?
  l. If not, what else would you need?
  m. How is this type of training helpful to people?
  n. What were a-ha moments in the training for you?

- Is there anything that you have not offered, either positive or negative, about what we talked about today that you would like to add?

Thank you for your time. The research team appreciates your willingness to share your experiences related to racial microaggressions. We may contact you again as themes emerge to see if they resonate with your experience. I will stop the recording now and we will say our goodbyes.

** Possible probes:

- Can you describe that more for me?
- What was that like for you?
- Can you tell me more about that?
- Take me there….
- Walk me though it….
- Tell me more…
- Why did you think that?
- Please give me an example…