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Blindness, deafness, silence and invisibility that shields racism in nursing education-practice in multicultural hubs of immigration

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ABSTRACT

Background: This paper relies on data from the multilevel, sectoral discussions held among professional nursing and sociology individuals.
Purpose: To present the outcomes of a reflective process on racism in nursing education and practice in the cities of Toronto and Paris.
Method: The method used was a reflection on research conducted by eight individuals dealing with racism at distinct stages of their professional career. The reflections are organized as a systematic description of facts, noted feelings, appraisal of issues, analysis of learned lessons, and lead to recommendations for nursing education and practice.
Results: The promotion of social justice and social inclusion has become a matter of nursing practice, yet a lack of critical discussion about racism with racialized students may result in feelings of being silenced. Increased awareness of racial negligence within a clinical setting can instigate change and allow nursing professionals to advocate for more culturally-sensitive care for a multicultural clientele. Insight from nurses with different professional status and from different racial backgrounds will garner an understanding of how the experiences of racism are in some ways individualized.
Conclusion: A collective reflection is required to understand the factors that underpin racism in nursing and can be used to elicit dialogue on a national and international scale in order to address racism in global nursing.

Introduction

The concept of race results from a colonial historical fabrication which benefited 18th and 19th century colonizers for the purposes of domination and exploitation (Amselle & M'Bokolo, 1999). Later, they also relied on the natural sciences and physical anthropology in a search to classify groups of human beings (Guillaumin, 1992). The idea that irreducible differences exist (usually presented in terms of biological make-up or culture) among human beings supports racism and discrimination. The history of medicine and its scientific knowledge has been constructed based on racial categories (Doron, 2013); the classifications of Blacks, Africans, Whites, Caucasians, etc. resulted from this historical knowledge and remain as epidemiological categories to the present day (Carde, 2011).

The roots of racism lead to representations and pre-judgments which undeniably influence the current practice of healthcare professionals. It is noteworthy that such categorizations do not imply an awareness of the arbitrary character of the characterizations nor their deleterious effects. Indeed, it is the healthcare environment that causes the absence of reflective criticism (Adam & Herzlich, 1999) because it does not perceive itself as a producer of social inequities, including racism. Previous studies have demonstrated that pre-judgments that do not challenge the inequitable access to a minimal level of healthcare still strongly affect the quality of care provided and considerably modify the treatment trajectories of clients (Carde, 2006; Cognet, 2012; Nacu, 2011; Prud'Homme, 2015; Sauvegrain, 2010).

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The purpose of this paper is to present the outcomes of a methodologically structured reflection on issues of racism in nursing education and practice in the cities of Toronto and Paris. This paper relies on data from the multilevel, sectoral discussions held among professional nursing and sociology individuals in these two key hubs of immigration. In these cities, the global movement of populations reinforces the mix of a resident population that includes second and third generation descendants of immigrants. As many of these descendants undertake post-secondary education, they bring an increasing diversity to the nursing student cohort and workforce today and for the years ahead.

France is a country of immigration and settlement, and it is "pushed" to interrogate its plural composition and its inter-ethnic relations in several societal sectors (e.g. organizations of work, education, trade and services). Race and racism are objects of powerful denial and invisibility in social relations influenced by power imbalance, normalization, and variable social status, leading to a state of uncritical racism (Trawalé, 2016). There is a current debate about the institutional mechanisms and production structures as source of inequalities as well as the labelling and treatment of social groups as races, which is considered to be the root of systemic, indirect, and invisible discrimination (Dhume, 2016). The notion of 'majority' defines the group of metropolitan, French-born individuals whose parents are also French metropolitan. Conversely, the notion of 'minority' includes groups of individuals who are subordinated because of "foreign" origins. Central to the French perspective of 'minority' is the process of minorisation, which is characterized by the situation of being under domination (Simon, 2006). Minority is thus a concept within social sciences, and specifically within health anthropology, because medical sciences, such as epidemiology and genetics, contributed to the long-lasting construction of racial prejudices and stereotypes in representations of race (Doron, 2016; Doron & Lallemand-Stempak, 2014).

Understanding racism in France's healthcare system requires a review of its historic and long-lasting social roots (De Rudder, 2012). Racism applies to what is abroad, strange, other, and heterogeneous (Guillaumin, 1992) and frequently results in situations of othering and segregation (Trawalé, 2016). This accounts for how racist attitudes, ideas, and behaviors emerge, as well as the way some verbal or physical responses are produced. To comprehend this context, it may be useful to consider the principle of secularism because it does not impose rules that neglect the reason of its creation: social pacification.

It is noteworthy to say that the removal of the term "race" from the French Legislation in 2013 did not attenuate the public debate about the contradiction of its term in a classical republican political model. In fact, there is growing debate surrounding the idea of *how to talk* and *how not to talk* about race in France, which is still framed by culture, family heritage, and place of origin (Devriendt et al., 2018). The suppression of the term did not make it disappear in the French society; a metamorphosis in the discourse indicates its persistence.

Current theorization of racism brings forward the contrast between racial and racist discrimination, which are particularly relevant to explain French health professionals' selection and decision to enroll patients in treatment protocol and clinical trial grounded from their perceptions of cognitive and behavioral aptitudes of non-Europeans patients (Cognet et al., 2017). Moreover, cultural and social obstacles are also at play when comprehension of health information and adherence to regime are required. So, groups of Africans, Maghrebians, Antillians, Arabics, Muslims, and Blacks are potentially at risk to be exposed to inequity in health treatments due to a racist discrimination.

For this reason, educators in France should recognize that social representations and pre-judgments across societal strata, and invite students to adopt a critical view of distinctive ways of perceiving social reality. In this way, educators have a crucial role in helping students liberate themselves from racist thoughts.

Racism within Canadian healthcare and educational settings cannot be explored without first considering racism on a broader systemic level. Although Canada was the first country to create a policy to protect the diversity of the Canadian population, overt and covert forms of racism remain evident. In fact, the reinforcement of multicultural ideology within society can passively augment multicultural racism, that is, the uncritical acceptance of exclusionary practices and racist attitudes as a result of displaying multiculturalism as a public value (Munoz, 2016). Testimonies from immigrants have revealed the impact of power relations on one's "identity, cultural production, and struggles for resources" (Munoz, 2016, para. 8). Thus, multiculturalism acts as a facade that suppresses the reality that racism exists in Canada.

Despite racism being primarily manifested through interactions in society on a broader level, such experiences should be explored through a more encompassing lens. The nursing literature tends to report the existence of racism in the scope of practice through an isolated, group-centered lens. It discusses the importance of cultural competence (Trueman et al., 2011) and experiences of racism from (mostly) Indigenous nurses and its impacts on decision making and practice (Vukic et al., 2012), as well as nursing students' experiences of racism (Schaefer, 2008). Black youth are especially disadvantaged in their schooling early on. As high school students, Black youth in Toronto are twice as likely to be placed in applied (rather than academic) classes compared to other racialized students. Black students are pressured by their academic counsellors to choose applied courses, and even when their parents have signed them off, educators enroll them in applied courses (James & Turner, 2017). These students have low self-esteem and self-efficacy based on the attitudes they perceive from the individuals around them, especially educators (James & Turner, 2017).

The knowledge generated from the authors' own experiences may be particularly informative for nursing professionals and students in other countries that are new destinations for immigrants and asylum seekers. We foresee significant impacts on the nursing profession due to current and unpredictable changes in the social fabric of populations. A better understanding of the complexities of racism will allow practitioners to spearhead change, and importantly, learn to care for multicultural clients, even when their setting may not be ideal.

This research used reflective practice as a conceptual framework. Schön (1983) states that reflection as a cyclical process allows a practitioner to learn from an existing situation, and the information newly generated when amalgamating such data can assist the practitioner to better navigate future situations. Through reflection, a practitioner can criticize tacit understandings that have grown up around repetitive experiences, usually within the scope of a specialized practice. This form of reflection has been socialized in nursing education to increase the use of self-awareness skills, the description of experiences, and the critical analysis of situations. In this way, new understandings can unfold and evaluations of the learning process are supported (Holm & Stephenson, 1994). The application of this conceptual framework guided the choice for the reflective method of research (Burns, 1994) used by our team of authors, who operate in a multicultural multi-ethnic metropolis. We are also from diverse ethnic backgrounds and have both observed and experienced racism in all strata of nursing from education to various healthcare settings. This framework guided our reflection about racism and discrimination in these settings. Since the methodology itself is not structured by questions, we were instead asked to think about an event, reflect on this event, and think about how we would have proceeded differently. This reflective exercise was guided by the conceptual framework.

Method

Design: This study used the reflective method of research described in Schön's (1983) seminal work on reflective practice, claiming that an effective practitioner can recognize a unique or puzzling event when it is happening and reflect on it. As a research method, reflection often leads its users to a changed perspective of the situation, leading to new ideas, and has the potential to uncover themes and possible solutions (Burns, 1994). The themes were created based on the conceptual framework of

reflective practice, as previously described. The themes were inspired by the phase of the analysis proposed by Schön (1983) and Burns (1994). This purposeful method leads to the evaluation of one's experiences with further reflection on them, resulting in a systematic description of facts, noted feelings, appraisal of positive and negative issues, analysis of lessons, potential solutions and the design of an action plan (Burns, 1994). The procedures we applied follow recommendations proposed by Fook (2011): (a) defining the topic; (b) working through a multidisciplinary lens; (c) choosing a perspective to integrate ways of understanding the human experience; (d) recognizing the legitimacy of the researchers own experience along with other individuals' contribution for the process of reflection and the proposed recommendations.

Location: Various locations (coffee shop, nursing school, university office, hospital, etc.) where we, the authors, conducted our reflections in different cities located in Canada, France and the United States of America.

Participants: Seven authors from the nursing profession with diverse professional identities. The Canadian team was composed of (a) a Canadian-born undergraduate nursing student; (b) a Canadian-born Master's program student; (c) an Argentinian immigrant, an early career nurse practicing in the USA; and (d) an immigrant nurse holding a PhD degree in nursing and an Associate Director position in a school of nursing. The French team was composed of (a) a French-born nurse holding a PhD in sociology, working as a university lecturer; (b) a French-born nurse holding a PhD in medicine with a Hospital Director position; (c) an immigrant nurse educator working in a hospital affiliated with a school of nursing, and (d) a French-born sociologist, a PhD candidate who studies racism and discrimination in a healthcare context. Our group included six females and two males. Our professional experience ranges from 5 to 39 years (excluding the 4th-year university undergraduate student) and our ages range from 21 to 60 years (see Displays 1 and 2).

Period: The individual and sub-team's reflections were recorded and analyzed from May to December 2018.

Data organization: Individual reflections were reported as short narrative texts containing an average of 300 words. These reflections were shared among the team and, due to the sensitive nature of their contents, a joint analysis was not conducted. Inspired by the procedures of the qualitative method of thematic analysis, the team created two displays to reveal systematic features of racism in personal experiences (see Displays 1 and 2), one with misleading situations of racism (see Display 3) and another display about the levels of impact of Canadian students' self-agency as potential past deeds (see Display 4). Each author individually analyzed their own writing and contributed to the development of the analysis section, adding their own thoughts. The intention was not to reach a consensus, but to present individual reflections as original and authentic material. The final interpretation of the compiled experiences substantiated the design of an ideal plan of "collective action" as a responsibility of all nursing social actors. For that, we worked with a Black, Canadian-born, young artist of Jamaican descent who helped us graphically represent our findings and proposed recommendations for action.

Ethical aspects: Critical reflection on the authors' personal experiences as a clinician, an educator, a student, a manager and a researcher is a creative practice activity. The authors were responsible for the production, interpretation, and reporting of their own self-reflections. The nature of this research method does not warrant an institutional research ethics review as it does not fit within the parameters of a research study (Tri-Council Policy Statement, 2014). Because the authors of this paper are the only participants in this study, ethical considerations about recruitment, potential risks, debriefing and supporting participants are not pertinent.

Results

This section presents the narratives and testimonies as they emerged, illustrating situations of racism lived by ourselves, other individuals, as well as clientele in both Toronto and Paris. Sharing our experiences of racism opened the dialogue to how our experiences may have overlapping elements, regardless of the use of different approaches to handling these and comparable situations. The diversity of our team of participants/authors — in terms of immigration status, professional identity, cultural affiliation, and racial genetic make-up — brought a kind of triangulation of empirical perspectives of racism to this reflective research. As evidence, selected reflections are presented in two displays of summarized accounts. These reflections briefly describe how racism operated in several social contexts regarding where we were born, our current work, study, and life. Display 1 introduces reflections on racism in the context of practice as university educators and researchers by the two lead authors.

From the newly emerged understanding developed in reviewing our "participant" observations and reflections, we corroborated other scholars' claims about the difficulty in tackling this form of racism (which is sometimes hard to identify), possibly due to the following four reasons:

(1) The large majority of racist practices result from social relations that go beyond the individual and are located upstream, supporting the broader sociological, political and economic reasoning for such practices (Cognet, 2011; Prud'Homme, 2015).
(2) These practices impregnate daily life until they become banal, invisible and inaudible.
(3) The banalization of these practices integrates them within ordinary life, a routine that facilitates tolerance towards racist individuals (De Rudder & Poiret, 2005).
(4) Due to such tolerance, the victims who protest against racism are labelled as paranoid and meddling killjoys.

These reflections give personal real-life accounts of the overt and covert racism that occurs in Toronto and Paris to people of color. They exemplify the power of racism as well as its ubiquitous nature in that it occurs even in spaces of education and professional practice; they collectively chronicle the process of racism and its lasting effects. These reflections simultaneously reflect racism's most troublesome features, its insidious nature. It is often difficult to pinpoint, which makes it hard to effectively combat; racism is institutionalized by being woven into many of our institutions including schools and workplaces, giving privilege to some and marginalizing others (Kubota, 2015). Our difficulty in identifying and tracking racist practices and consequently the effort required to encourage victims who have had to "deal with it" to express their experiences, is disturbing. Worse, our collective blindness and deafness to these questions end up making the victims oblivious to the issues that occur.

Voices from the field

The clientele are not the only ones to reveal racist attitudes. The caregivers are just as impregnated by depreciative ways of seeing those they consider "different" from their origins; this was identified in several contexts of nursing work and education in Paris.

When we are (she touches her hand to designate her skin) of this color, it is not easy… it is like they see us as their domestic maid, we should this … we should that … they are more demanding towards us than to the others.

Within 15, 20 years they will see … there are a lot of immigrants!

Display 1 Authors' reflective statements of experiences of racism in academia, research and education.

Reflections

When I was enrolled as the first foreign student, a Brazilian, in an English-French nursing PhD program, I found my "whiteness" was not a shield. Many individuals barely accepted the fact that my first name was not "Margarita". I had an unequivocal impression that I was perceived as being one of the "others" who live in countries south of the USA. Residents from all countries below that line were called 'Latinos', composing an undistinguished cultural and racial group. I was repeatedly asked: "How is it that you do not speak Spanish?" "Are you Brazilian, really? With an Italian name? You look like an Arabic woman! Not Mexican, at all?" It was impossible to be indifferent to the discomfort due to such culturally oppressive comments and attitudes. Paulo Freire's ideas of critical awareness and emancipatory education instilled in me the courage to be resilient. I was proud of my strength in studying in a bilingual PhD program, having to think and work in what was my third language. "Wow! Really!? You speak more than one foreign language? Is this typical of your people?" It was a tiring process of self-affirmation! I am positive that any pinch of racism or discrimination was never based on my skin color or my unidentified Black or Indigenous heritage. It was based on my audacity to demolish an image of a less successful "Margarita". Indeed, I arrived with an English name but also (proudly) speaking Spanish as a fourth language. White, Caucasian, with two doctorate degrees and fully able to contribute to the education of Canadian nurses for the last 15 years. Bringing my nursing knowledge grounded in a non-Anglo-Saxon academic world. Fully valued at last? Not at all! (non-racialized Brazilian female immigrant, nurse educator and researcher in Canada)

The starting point of my studies in sociology came from observations I made while I was a nurse in a psychiatric hospital taking care of the resident population of Seine-St-Denis (north-east of Paris). During the 1980s, I noticed a rather marked increase in psychiatric hospitalizations under police constraints of young men from the Paris suburbs who were then called "the second generation of immigrants" which signified their externality to the French nation. These youths were considered dangerous to others, viewed as deviants of a psychopathic nature engaged in petty crime. Psychiatry had the mission to contain them rather than re-educate them. This observation made me an interrogator of the treatment of minorities in France, and was the starting point that led me to university studies and more particularly to the sociology of interethnic relations, racism and the analysis of racial discrimination. Another catalyst was my observations of gender relations. In my first years of practice as a nurse, I realized that work in the hospital was organized by gender, with men occupying the most prestigious jobs and those said to be 'responsible', and women were usually nurses, nursing assistants, and secretaries. While White French women were traditionally in less favorable situations than White French men, they were more likely to hold managerial positions than French nationals from the overseas territories or colonies; the latter were generally placed in the lowest and most precarious job categories. In other words, the progress of White French women was realized on the backs of minorities. (female nurse, sociology educator and researcher)

> Why are you not going to do your research elsewhere — with the physicians who refuse to care for those who hold an AME or CM[1] card? Here [discrimination] is not possible, we follow a protocol, we provide care and that's it.
>
> (a Paris team researcher)

Uncovering Paris nursing students' experiences

Nurses and auxiliary-nursing students are stimulated throughout their education to develop qualities of otherness, listening, and empathy, allowing them to progressively approach the multidimensional aspects of a client. They are also apt to practice in a context where points of view within a multidisciplinary team are inevitably diverse. However, even within a multi-professional context where humanist values of respect, dignity, tolerance should prevail, neither the nursing students nor their teachers are protected from the pre-judgments and stereotyped representations existing in the healthcare system and civil society.

Our Paris authors' team recognized that nursing students and health professionals perceive social differences that distinguish and characterize individuals by ethnic group, keeping some at the edge of "us", or even reject them because of a supposedly essential, irreversible foreignness. In a school context, this ordinary racism can be evident during a break, a collaborative job, a course, in the hallway, in the lunch or break room. Comments are made about clothes, choice of words, or behaviors that are usually linked to one's religion or culture. Some attitudes are stigmatized, some jokes apparently banal, and sometimes the racism of the remarks are unperceived:

> Ah! Do not blame her, she comes from 'the islands'.[2]
>
> Muslims are chaste.
> Africans are resistant to the pain.
>
> The French do not know how to breastfeed. (an educator-Paris team).

During their clinical placements, the Parisian students reported cases of insidious attacks that detracted from their work-related sense of well-being. It is known that trust within the healthcare team is necessary for the clarification of students' questions, doubts, and uncertainties linked to their practical learning; but under such adverse circumstances as the following examples, how can students feel confident?

> The manager of a home care agency asked the school of nursing to remove a student from a clinical placement because her skin color and appearance were provoking fear among the clients …. When we [the teachers] argued that the legislation prohibits discrimination, the manager replied that she could lose her private sector [paying] clients, that having clients in fear of nursing personnel was not ethically acceptable.
>
> Do not worry, this sometimes happens, you know … the patient is crazy, this always happens in our environment, we should become familiar with it.
>
> Well, it's weird that the Blacks tan! (an educator-Paris team)

Such experiences can interfere with the development of a student's professional attitude, as the following example shows, and reproduce a

[1] AME and CMU cards are documents that allow access to regular and urgent medical services offered by the French government to undocumented individuals in need of humanitarian aid.

[2] This refers to French territories located abroad, mainly the French Antilles.

Display 2 Student authors' reflective statements of experience of racism in education settings.

Reflections
Sensibility and interest in the analysis of racism, social class relations or patriarchy allegedly come along with awareness of our own position in power relations at every step of doing research. In my work, questions of power relations were crucial during fieldwork. Over several months of observations and interviews in three university hospital centers in Paris and its suburb, and in Montreal, I realized that these hospitals were frequented by a large proportion of people from lower and working classes and/or racialized people and/or immigrants. My research discusses the ways health professionals (physicians, nurses, and auxiliaries, among others) negotiate with and mobilize the social characteristics of their patients and how they categorize them. My work pays close attention to the differences between professionals themselves: how their own social characteristics impact the ways they apprehend their patients' social characteristics. Similarly, I think the researcher's awareness of (and participation in) power relations must be part of her or his sociological work itself. In my case, how should I categorize the agents I observed in my notes? How can I report their social characteristics, knowing that they are always constructed in relation with other agents, including the researcher? Given how racialized people are assigned to a minority group, and being a White person, how can I avoid a reproduction of these logics? How can I interrogate geographical and social origins without replicating assignments to "visible otherness" or deviance, and thus, exert symbolic violence on participants? Concerns for such issues invite me to question how I was perceived in the field. Being a young White girl with the ethos of the educated upper class (taking notes, being silent and shy, but also talking to physicians with a certain confidence), I have often been seen as a medical student myself, someone a nurse or support staff do not often talk to. (Caucasian female, French-born, sociologist, PhD candidate)
I have had many experiences with racism. I approach every situation with an understanding that racism is a part of life in Canada, but it is taboo to acknowledge that racism is present in all aspects of life, including healthcare. Some instances are neither covert nor subtle but are shocking. For instance, I've entered a patient's room wearing scrubs, traditional white nursing shoes, a name tag and a stethoscope around my neck, introduced myself, and been told that the tray is ready to be picked up; I've been addressed by a racial slur, and even asked, after I've introduced myself, whether I'm really a nurse. Repeatedly, my qualifications are questioned, and when it is confirmed that I am a university-educated nurse, there is a surprised reaction. Racism in a clinical setting can be covert and harder to detect, proved or pinpointed, such as questions about where I was born or educated, with the assumption being that I do not belong or am not truly Canadian. Some patients express surprise that I am an in-charge nurse; sometimes it is assumed that the person I am orienting is actually in authority, due to racial differences. These incidents have a profound impact on my self-esteem, especially when I'm a well-educated nursing professional who has earned a Bachelor of Science degree and several postgraduate diplomas. I find it difficult to retain my composure and have a successful shift while dealing with the aftereffects of such racist actions and comments. It is also surprising since I practice in one of the more multicultural, tolerant health care facilities in the country, yet this sort of event is not uncommon. From having to deal with repeated acts of racism, I have emerged with a positive approach based on maintaining the resolve, strength and the ability to handle various situations with grace, poise and a determination not to react to racism. (Black male, Canadian-born, Trinidadian descent, and MN student)
In class, when a professor talked about how oily foods are harmful for our bodies, and should be avoided despite her love for "Indian food", she looked directly at me several times. I felt singled out and uncomfortable, especially because I am not of Indian descent. An assumption was made based on the pigment of my skin. At that moment, I felt as though all South Asians are seen as a package, even though there are significant differences among South Asian groups. At that time I felt that the teacher-student relationship was unidirectional because the teacher holds a lot of scientific health knowledge and clinical expertise in the field…. One of the reasons I chose my nursing program was because it is located in downtown Toronto, one of the most multicultural cities in the nation. I realized immediately that racial differences were barriers for some students; for instance, some international students had strong accents and were often left out during orientation events…. Exploration of the diverse ethnic backgrounds at my school of nursing would be excellent for teaching cultural competence and cultural humility. We are told to respect and cherish differences that arise when interacting with patients, but why don't we focus on the differences within the classroom first? Students have the potential to teach teachers, not only about cultural competence or cultural sensitivity but cultural humility. We cannot cherish differences if we don't know what these differences are, and this can only happen if we are humble enough to say, "I don't know much about you, but can you teach me?" In clearing assumptions and reaching a common understanding, the professional relationship between a teacher and student is strengthened. (Canadian-born, female undergraduate nurse student of Bangladeshi descent)
On arriving in Canada, I learned quickly that the major premise of "multiculturalism" was that "cultures" wouldn't melt, and that I was expected to 'hang out with my own people'. Too bad for me, 'my' people, as I regarded it, was humanity. I perceived from my personal experience that beyond 'tolerance', good intentions and official discourse, the "multicultural" model was being carefully manipulated to emasculate "Brown males" [who are considered potential terrorists, women abusers, gang members] and exclude them from financial, social, intellectual, even mating prerogatives.... It was disturbing to witness horizontal animosity among ethnic individuals. A statement of whiteness among non-Aryan/Anglo-Saxons was all the White supremacists needed to justify their views that light color traits bestowed racial/financial/social/mating privileges, granted by genetics as opposed to merit. Applying for my BScN wasn't any different: I was directly confronted by the "facts" of my age, my long past history of foreign education, and my "lack" of English-speaking skills. I applied for, paid for, and aced three courses before they considered me fit to enter the program. Regrettably, even after graduation, I saw peers who were concerned about their low grades get the most sought-after positions right away [males/females, young, White/Filipino/Eastern Europeans]. My B+ average, however, granted me little more than rejection on the job market. Racialization, sexualization, and ageism applies to the nursing world in the USA where I live now, and in Canada. It appears to make societal sense that basic nursing is a career for women of minorities, with all the racial, sexist, discriminatory, even self-deprecating implications entailed therein. So, wherever a nurse may practice, it may require a steadfast quest, time, failure, and experience to find work fit for her/him. Seven years after graduation, I consider myself blessed, and grateful for the several [ethnic] professors who empowered me and propelled my professional vision. (male, Argentinian-born, immigrant to Canada, nursing alumnus)

poor image of the nursing profession.

> A first-year nursing intern was uncertain about the success of his practicum in an upper class setting in Paris, due to his Black image. He asked the coordinator to transfer him to a neighborhood where he could more easily connect with the social "environment". His request was not granted and, in fact, the internship went well, leaving the student doubtful. (an educator-Paris team)

Students' awareness of racism in nursing education in Toronto

When considering Canadian values of respect for multiculturalism and diversity, the students recognized that being socialized in Canada may equate to not acknowledging race. This failure stifles the voices of some racialized students, deterring them from identifying and speaking about race in their own education. Canada prides itself on racial diversity, and race is a "forbidden" topic in the national agenda of correctness, including the nursing profession. Some students — identified as "people of color" — suppress their reactions because of this:

> If one were to speak out against it [racism], the individual would be branded as [overly] sensitive, a troublemaker or problematic. (Toronto undergraduate nursing student)

The Toronto student-authors claim that in addition to the lack of a concerted, direct, and systematic plan of tackling the issue of race by nursing faculty, these webs of interplaying factors perpetuate a veil of silence and normalization of racism in university education. This normalization of racism seems heightened in the classroom and practicum settings, leading nursing students to become unable to recognize racially motivated aggression. Without openly discussing the possible hypotheses for multi-faceted racism as a societal imbricated phenomenon, such perpetuation unfolds.

Awareness and acknowledgement of racism seems absent in academia, even among Master in Nursing (MN) students. Exposure to critical philosophies does not seem to help graduate students locate their own place in the world, as the following experience in a Quebec university shows:

> In a three-hour seminar, I discussed Freire's pedagogy of the oppressed with Quebec-born Caucasian, female MN students who seemed blind about their own country's history of oppression, and attributed negative conditions to immigrant/refugee populations themselves. The group included one male Canadian-born Indigenous student; he was the only student to express an understanding of Freire's philosophy and he acknowledged its resonance with the historical oppression lived by his Indigenous people. (an educator-Toronto team)

The Toronto student-authors also identified subtle forms of racism integrated in the empirical database used to guide nurses' clinical practice and their preceptorship. Moreover, in the French context, an educator and two researchers critically reviewed the role of major healthcare stakeholders' inaction and the normalization of racism within the healthcare culture (see display 3 for both features evident in Toronto and Paris).

If these clinical examples and practice-challenging issues were brought to the attention of racialized students with no critique, it would likely result in feelings of being silenced. Alternatively, critically discussed examples and issues can become inspirational and trigger action, with students using their self-agency to address issues on a university-wide and society-wide level (see Display 4). Increased awareness of racial negligence within a clinical setting can be the premise for change, and could encourage nursing professionals to advocate for multicultural clientele so they receive culturally sensitive care. Using this knowledge, nursing professionals can also work towards addressing racism on a broader, societal level.

Discussion

The issue of racism in the healthcare sector remains underexamined and largely ignores the implications of implicit blindness, despite the fact that some studies have identified that racism and racial discrimination have infiltrated and guided the practice of healthcare professionals (Bertossi & Prud'Homme, 2011a, 2011b; Cognet, 1999, 2004; Fassin, 2000; Guillaumin, 1992). On the other hand, we must be sensitive to the reality of health conditions related to a client's clinical preconditions; reactions to some treatments may justify legitimate

Display 3 Misleading acknowledgment of racism in clinical context.

Racism in nursing practice
In Toronto context
- Assessment of dark skin coloration of Black patients in situations of (a) electrical burn; (b) AGPAR assessment in Black newborns; and, (c) assessment of pressure ulcer stages.
- Normalization of sleep apnea among Black, obese individuals.
- Trivialization of sickle cell disease symptoms mostly for African descend patients, leading to under-screening and poor pain management.
- Representation of stoic individuals (Japanese, Black) regarding their manifestation of pain, leading to inadequate implementation of pain management interventions, such as a lower dose of pain medication for wound debridement and physiotherapy.
- Preconceived notions of Black individuals' physical strength, leading to decreased screening of hypertension among young individuals.
In Paris context
- Acceptance of Caucasian senior clients' fear provoked by the bodily appearance of Black nursing personnel.
- Managers react to Caucasian seniors' discomfort by changing the care assignment to non-racialized personnel.
- Healthcare administrators privilege Caucasian seniors' preferences for non-Black nursing personnel over the legal rights of Black nursing staff.
- Anti-Semitism and mistrusting comments towards a nursing student remain unaddressed by the hospital administration, justified by the patient's mental health condition.
- Administrators of healthcare organizations (including physicians who occupy a Chief-of-Department position) hardly recognize a racist episode among the clientele's comments and attitudes; even its frequency becomes normalized.
- The existence of racism in French healthcare organizations appears incongruent with the stated values of their health professionals.

Display 4 Levels of impact that have the potential to be produced by nursing students' self-agency.

University-wide	Society-wide
- Awareness of consequences of prospective actions to influence change as a barrier/problem. - Identify an issue, bring colleagues together, and decide to act together: (1) can bring it up in a classroom discussion; just simply discussing the issue and potential ideas on how it can be addressed; (2) work with student course unions to facilitate workshops. - Talk to faculty about including discussions about racism in the curriculum/learning activities. - Reach out to minority school groups in the university setting to discuss issues of racism and how it can be addressed. - Bring back to students and other nursing coworkers in the clinical placement to show mobilization of an informal anti-racism group.	- Use social media as a platform to disseminate issues and concerns. - Reach out to religious leaders (or community leaders) who can advocate for a culturally sensitive approach in education. - Reach out to the community to identify a place to experience sharing and support gathering (e.g., gym, club, parlour, barber shop, coffee shop, gay club, virtual community, place of worship) - Reach out and individuals' support for self-education about the presence of racism in daily life. (e.g., gaining strategies and hearing life experiences).

differential treatment between clients.

In France, schools of nursing cannot continue to neglect situations of ordinary racism; faculty advisors and preceptors need to be prepared to intervene when racism threatens their students' self-esteem. Hospital and healthcare service values and ethics require that professionals take a position to defend the citizenry. It is not a matter of a distorted representation of the world but of proposing a different point of view to animate individual judgment and critical thinking. The educator's professional responsibility is to instigate dialogue to allow students to feel free to express their experiences as healthcare providers, and also to comprehend how their own perceptions of others may lead to pejorative behavior. It is about respect for human and civil rights. Students should receive guidance through the process of introspection and self-interrogation to authorize them to become more open to the ways of thinking of other individuals.

France, which recognizes itself as a country of immigration and settlement, is more or less compelled to consider its plural composition and the interethnic relations generated in healthcare, work, education and other service organizations. The pool of employees includes immigrants and their descendants. These organizations have become spaces of inter-ethnic relations where ordinary racism may occur. The clientele's hostility and tendency to "other" racial minority health professionals have been documented for more than 25 years (Bertossi & Prud'Homme, 2011a; Cognet, 2004). These longstanding issues emphasize mostly the skin color or origin of professionals (Bertossi & Prud'Homme, 2011a; Cognet, 1999; Fassin, 2000, 2001; Guillaumin, 1992; Kassembe, 2001), and are sometimes expressed as a form of domination (Cognet, 1999; Fassin, 2000, 2001). We urge caution regarding the possibility of racism being produced by professionals towards their clientele (Kassembe, 2001).

Our findings are subject to some limitations. The absence of a university nursing undergraduate program in France limited the invitation to Paris students to contribute to the production of this scholarly reflection work; their experiences may not reflect those of all students. It is noteworthy that the University of Paris 7 (UP-7) is offering courses in the areas of social sciences and humanities by anthropology and sociology professors affiliated with the University's Departments of Medicine and Social Sciences among them, one of our co-authors.

We have not explored the intersection of other identities (i.e., sexual orientation, religion, socioeconomic status, etc.) in relation to the experiences of racial minorities. Being cautious about conflating race and socioeconomic status, another limitation is the absence of a newcomer professional or student from low and middle-income countries who may face a distinctive experience regarding compliance with social expectations in regards to behavior, etiquette and language.

Although Canada is often depicted as a cultural mosaic, it can be seen that this cultural idea reinforces racism by encouraging the passive acceptance of existing societal structures that deny and recontextualize racism in Canadian discourse (Gulliver, 2018). Healthcare professionals focus on a medical model and tend to avoid discussions of the relationship between race and environment. Consequently, the complex and broader factors which lead to racism persist, while we mostly focus on micro-level acts of racism. Any discussion of racism in Canadian healthcare must address important issues of power imbalances, which are particularly relevant for non-Indigenous healthcare professionals and the Indigenous clientele whose healthcare issues are systematically ignored (Boyer, 2017).

It is encouraging that a recently published Canadian nursing book discusses racism and its pervasive effects on the racialized population's health, the healthcare system and the nursing profession (McGibbon & Wambui Mbugua, 2019). This is a positive signal of progress and change within nursing education and practice, with the potential to influence the minds of future healthcare providers in the care of their patients. Healthcare educators and professionals need to promote frank discussions about racism among colleagues as current broad discussions about team building do not capture the realities of racialized healthcare providers. As in France, the fear of Black bodies in Canadian society (Mullings, Morgan, & Quelleng, 2016) is prevalent, not only among patients but also affects social relations between Black and non-Black healthcare providers. Micro aggressions are often covert, hard to concretely identify and often do not elicit concern from the general public (Fleras, 2016). They are frequently unacknowledged and leave the recipient without recourse. The dichotomous practice of addressing cultural competence regarding patients while simultaneously neglecting cultural or social relations within the nursing profession, shows the complexity and pervasive nature of racism and its impacts on society. For instance, a recent federal publication on measuring health inequity in Canada did not consider race as one of the stratification variables (Canadian Institute for Health Information, 2018).

When society at large will have a greater awareness of this issue, nursing students, professionals, and educators should hold an open dialogue about racism as an opportunity for joint reflective practice. This will allow a greater understanding of how racism is perpetuated through perceived power imbalances. As novices, nursing students tend to steer away from addressing concerns that may arise — whether this be normalized assessment practices, correcting faculty in their choice of words, or even their body language when race is the topic of discussion. It is important for nursing students to acknowledge that nursing faculty and practitioners are their prospective colleagues.

With exceptions, the alleged power imbalance that perpetuates racism is self-constructed by nursing students and is based on assumptions. By recognizing their rights as citizens and refusing to submit to a

label based on race, the next generation of nurses can initiate change and tackle racism. In the transition from the final year of nursing school to the workforce, their integration into the workplace is stressed, but integration implies adapting to current situations; a more appropriate term is the inclusion of nursing students in the workplace. Nursing students have the ability to spearhead change within the domain of nursing, and this begins with acknowledging that perceived power imbalances are a result of assumptions and norms. By challenging these ways of being and growing from this mindset, the nurses of tomorrow can tackle the perpetuation of racism in nursing.

The assumptions which allow for racism to perpetuate must also be replaced with an increased awareness of one's rights. Allowing discussions to take place in educational settings can allow students to not only recognize their rights, but to learn to protect them. Guiding these discussions using various frameworks, such as Sen's (1993) work on individual entitlements and capabilities are integral in reframing student's perception towards human rights and freedom. Specifically, Sen's capability framework encourages individuals to analyze their own well-being, which naturally encourages one to explore any factors preventing one from achieving this state of well-being. Using this knowledge, Sen encourages individuals to evaluate one's social arrangements to ultimately propose social changes in society, and striving towards making these changes. This framework moves away from the passive acceptance of one's social surrounding, and allows individuals to take on a more active role in redefining their well-being, and shaping their surroundings to achieve a desired state of wellbeing. Integrating other human rights frameworks, including the World Health Organization Constitution (World Health Organization, 2006), as well as the Universal Declaration on Human Rights (United Nations, 2015) into nursing education can broaden student's understanding of their rights. Facilitating the critical appraisal of their surroundings using these lenses can bring light to changes that need to be made, and how these changes can be advocated for.

The dominant stance or ideology is race-inclusive and assumes equality for all citizens. This may be a well-meaning stance, but can have deleterious effects on minority groups and their lived experiences. As seen in the reflections and at an aggregate level, racism still exists and affects the daily lives of racialized minorities in all sectors. Being "blind" to race negates the realities of these individuals and gives society license to ignore the issues and silence any challenges brought by minority racial groups or label confronters as being militant, exaggerating and self-victimizing. This cycle leads to the pressure on minorities to suffer in silence and gives racism an environment to proliferate and continue unmitigated. Race is a complex web of relations, and culture and ethnicity are concepts that are inextricably linked with race. The paradoxical celebration and promotion of multiculturalism, accompanied by the stigma and silencing of discussion on race relations, leaves all social actors under pressure to not disturb the status quo. Positive changes are being made in society with race being introduced into education, more racial diversity in media, and more visibility of racial minorities in higher education and senior employment positions. With younger generations witnessing these changes, race can be reframed in a positive manner for the upcoming generations.

Our discussion about racism in nursing, based on our reflections and experiences, made us realize that change is possible and is needed, led by individuals dealing with racism in the nursing profession. New knowledge emerged and we envisioned a new state-of-the-art for the nursing profession, celebrating its inner diversity. We suggest progressive action for those who hold the possibility of transforming the future. Educators should optimize their opportunities to evolve the educational system towards one more sensitive to the untold struggles faced by racial minorities among students, educators, and the administrative staff who support the teaching-learning process.

We also foresee taking interchangeable roles between students and educators during mutual collaborative processes of teaching-learning through critical dialogue (Shor & Freire, 1987). The new knowledge reshapes existing ways of knowing by engaging in bi-directional dialogues. Despite the occurrence of disruptive actions, the "system" remains operated by individuals, so they are the core of the general education about the actual assets and potentialities of racial minorities. Our recommendations are presented in graphic form in Fig. 1 as a vision of constructive reality. The journey to liberation begins with the (1) seeds of change, the embodiment of the desire nurses possesses to bring about changes in the healthcare field. The seeds then enter the soil of society, a region consisting of the institutions orchestrating nursing education, the health care organizations supporting nursing practice and the patients/clients receiving their care. This portion of the diagram acts as the initial and continued exposure to racism that nurses experienced within their education and practice. Following are the (2) roots of resilience, an illustration of the pathway nurses endured while affecting change in their profession in the midst of racial segregation. Arising from this conflict is the (3) trunk of triumph, representing the growth these nurses cultivated when reflecting on their triumph over their experiences with racism in nursing. Finally, the (4) liberation fruits from racism represent the power that nurses now possess to combat racism in their education and practice. The words accompanying the diagram function as a linguistic compliment to this artistic rendering, consisting of 14 recommendations, hence the presence of 14 fruits among the branches of the tree. Recommendations are outlined below:

1. Deconstruct the "forever-victim image" and adopt a more audacious role as a public educator, even when facing fear (Freire & Shor, 1986), to teach the society about yourselves as racial and ethnic minorities.
2. Replace the silence with eloquence, steer and renew discourse about yourselves and your racial and cultural affiliation.
3. Applaud, celebrate and honor a proud image of being a conscious member of the nursing profession.
4. Cease to see in your professors and colleagues the image of your enemies.
5. Reflect on the differences and challenges brought by other racial minorities.
6. Challenge yourselves, your professors and superiors to teach you "how to learn to improve your performance", to develop your inner potential.
7. Use your right to dream about a better future and create concrete, feasible plans of action.
8. Build partnerships with professors and colleagues to help you to overcome the pre-set minimal standard of academic and job performance "attributed" for racialized minorities.
9. Become aware of the risk of becoming an oppressor in the education system.
10. Use the social power of the numerical majority to advocate for changes that rebuild the social image of racial minorities in nursing.
11. Replace distorted images and representations about racial minorities' intellectual richness by actively participating in initiatives for using and generating scientific knowledge in academia.
12. Use your talents and seek intellectual partnerships, aiming to become a scholar in the nursing global community.
13. Act as an ambassador by creating opportunities to educate professors and colleagues about your sense of belonging to a racial minority.
14. Replace a submissive role by an engaged learner in your own process of refinement (see Fig. 1).

Lastly, we address the conventional discussion of a methodological limitation of a qualitative study. In this exercise of self-reflection, based on the authors'/participants' personal truth and vision of the world, they are the natural experts who hold the authority to confirm the final interpretation of the findings (Sandelowski, 1998). No sampling procedure was applied and no criteria of inclusion/exclusion were used. In

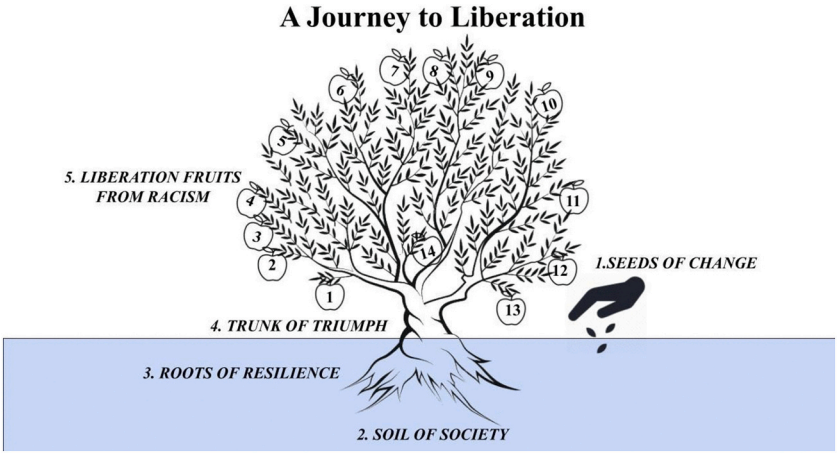

Fig. 1. A Journey to Liberation.

fact, the authors were already in previous intellectual partnerships and decided to take the challenge of reflecting and reporting on this socially relevant issue that jeopardizes the humanistic and social inclusive nature of nursing care. Moreover, an action plan as recommended by Burns (1994) as the final stage of the reflection was not conceived. Instead we recommended a series of changes needed before any action plan could be designed.

Conclusion

As a society, we have been race-blind, diverted from addressing the topic of racism and thus, not acknowledging this very real phenomenon. This race-blindness is so pervasive that it has permeated official documents, where there is a marked absence of this topic. In the nursing context in both Toronto and Paris, we have been socialized not to see race and, in fact, not accept its existence. There are racial disparities in the health sector and ignoring its existence is a disservice to visible minority populations and to the nursing profession.

Special attention is needed for the complexity of acknowledging racism in host societies that welcome immigrants and refugees. This is occurring in the current transformation of many countries as new destinations for the global movement of populations. With an increasingly multicultural clientele group, it is important that nursing students, practitioners and faculty have access to literature that will explore the phenomenological experiences of racism from various perspectives.

It has become a matter of nursing practice to promote social justice and social inclusion. Insight from nurses at different stages of their professional career and from different racial backgrounds will garner an understanding of how the experiences of racism are individualized in some senses, but are alike in others. A collective reflection is required to truly understand the factors underpinning racism in nursing, and can be used to elicit dialogue on a national and international scale in order to address this issue.

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