

**THEMES OF RACIAL DISCRIMINATION IN THE EXPERIENCE
OF BLACK FEMALE NURSE MANAGERS**

by

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A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Department of Sociology and Equity Studies in Education
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Doctor of Philosophy 2009

Paulette Marcia Stewart

**Department of Sociology and Equity Studies
University of Toronto**

Abstract

Most studies on racism in Canadian nursing show that nurses of colour, particularly Blacks, encounter patterns of race-based discrimination in varying degrees within their healthcare workplaces (Calliste, 1996, 2000; Collins, 2004; Das Gupta, 1996, 2002; Hagey, Choudhry, Guruge, Turriffin, Collins, and Lee, 2001; Head, 1985; Turriffin, Hagey, Guruge, Collins, and Mitchell, 2002). These studies suggest further that the discriminatory practices and attitudes entrenched within Canada's healthcare organizations operate in myriad ways, and can create significant problems for racialized Canadian nurses.

The few previously existing Canadian studies on racialized nurses' experiences of racism in healthcare workplaces do not pay adequate attention to the perspectives of Black female nurses in leadership positions. To address this dearth of information on Canadian Black female nurse leaders, this study examines the impact of race on the workplace experiences of Black women in nursing leadership positions.

This study employs a theoretical framework that combines integrative antiracism and black feminism to examine the effects of race on the day-to-day experiences of a cohort of 16 African Canadian female nurses in formal leadership positions. The participants in the study were recruited from various healthcare facilities and settings

within the metropolitan Toronto area in Canada. In the course of in-depth, face-to-face, semi-structured interviews, the participants were asked to share their perspectives and experiences as nurse leaders. Qualitative data analysis for the study showed that they face unique challenges as nurse leaders because of institutional racism as a practice existing in their workplaces. The findings of this study -- consistent with previous studies done in Canada and Britain -- are that themes of racial discrimination in healthcare settings and institutions negatively affect experiences in the workplace for Black female nurses.

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*You may write me down in history
With your bitter, twisted lies,
You may trod me in the very dirt
But still, like dust, I'll rise.*

(Maya Angelou, 1978).

First of all, I am deeply thankful to my faithful Lord and Saviour Jesus Christ for sustaining me throughout the preparation of this thesis.

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CHAPTER ONE

BACKGROUND AND INTRODUCTION

Introduction – Study Overview

It is noteworthy that Canada's human rights legislation at federal, provincial and territorial levels recognizes race, ethnicity, and language differences as fundamental characteristics of Canadian society. The Ontario Human Rights Code states:

Every person has the right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, same-sex partnership status, family status or handicap. [1981, c.53, s.1; 1986, c.64, s.18 (1).]

Similarly, the Canadian Charter of Rights and Freedoms [Constitution Act, 1982 (79) Part 1] explicitly states:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, religion, sex, age or mental or physical disability [15. (1)].

But despite the existence of the constitutional guarantees noted in these acts, and Canada's much vaunted exemplary position on a broad range of human rights and social justice issues, "...many people have been, and continue to be oppressed, marginalized, and excluded from meaningful participation in Canadian society" (Moore, 2001, p. 25). In a similar vein, Galabuzi (2006) points out that there is increasing evidence to suggest that "Canadians continue to attribute unequal social worth to people of different racial

origin despite the public's awareness and general acceptance of democratic principles of equality and justice" (p. 36).

Mounting evidence reveals that in spite of widespread awareness of Canada's anti-discrimination legislation, racism, racial discrimination, xenophobia and related intolerances are widespread and everyday occurrences in Canadian society (Agnew, 1996; Agoc, Harish, and Jain, 2001; Essed, 1991; Galabuzi, 2006; Hagey et al, 2001; Henry & Tator, 2006; National Anti-Racism Council of Canada, 2002, 2007; Ontario Human Rights Commission [OHRC], 2005). The awareness that racism is embedded within the existing structures and institutions of our society is evident in the following statement by the Registered Nurses Association of Ontario [RNAO], 2007): "Racism and cultural oppression have been realities for many minority groups living in Canada" in spite of Canada's "...long standing multicultural identity and a tradition of acceptance of diversity" (p. X).

The Problem of Study

...even in countries where...people have worked sincerely to establish an egalitarian society, prejudice and discrimination are still facts of life. People are usually more comfortable with people of "our own kind", and likely to be cautious, intolerant or uncomfortable with, or dismissive, suspicious or fearful of, people who differ from them in various ways... As in society, these attitudes also pervade the workplace.

(Truida Prekel, 2003, ¶. 3-5)

The purpose of this study is to explore the questions: Are prejudice and discrimination indeed 'facts of life' when it comes to the work experiences of Black female nurse managers in Metropolitan Toronto, Canada? Furthermore, how do notions of race influence their everyday experiences?

The discipline of nursing in Western contemporary societies is recognized as a predominantly female profession (Barbee, 1993; Berg, Rodrigues, Kading, and De Guzman, 2004; Coffman, Rosenoff, and Grumbach, 2001; Dombeck, 2003; Marks, 2000; Spratlen, 1998). Although Black and other racial minority women have made significant inroads, the profession is still overwhelmingly dominated by White women in Canada (McPherson, 2006), the United Kingdom (U.K.), and the United States (U.S.) Barbee, 1993; Barbee & Gibson, 2001; Keepnews, 2006; Puzan, 2003). À propos of this, a recently published RNAO, 2007 document, Embracing Cultural Diversity in Healthcare: Developing Cultural Competence, states:

Nurses from visible and non-visible minority groups, working across Canada in different healthcare environments, speak of their experiences of discrimination and racism and the challenges of working effectively in such environments...Canadians of Colour, First Nations' peoples... [and so on], have made clear that there are ways and times they have felt unwelcome in nursing, in healthcare and in the workplace. They talk about treatment in the workplace that feels uncomfortable -- either due to outward hostility or subtle discrimination. (pp. 17-18).

The RNAO authors also note: "...although the healthcare workforce is becoming more diverse, this diversity may not always be reflected in senior leadership and middle management levels" (p. 18). While there is no reliable and readily available data on the representation of ethno-racial minority women in nursing management positions, a small but growing body of research suggests disproportionately smaller numbers of racialized women occupy these positions compared to Anglo-Saxon women (Collins, 2004; Das Gupta, 1996, 2002; Hagey et al, 2001; McPherson, 2006; Turriffin, Hagey, Guruge, Collins, and Mitchell, 2002). What struck me, after a comprehensive review of the literature, is that there is virtually no research available that has directly examined Black Canadian nurse leaders in Canada's healthcare workplaces. To my knowledge, this is the

first study to look at Black Canadian nurses in managerial and formal decision-making positions in Metropolitan Toronto, the geographical area employing the largest number of nurses in Canada.

My contention is that this dearth of literature underscores the need for research on Canadian nurses of African heritage in healthcare management positions. Nursing scholars like Dr. Linda Lee O'Brien-Pallas have studied many nursing work life issues -- such as workload, autonomy and overtime -- extensively. However, to date, factors such as race and ethnicity and the impact thereof on racialized nurses' work life have seldom been a research focus. Reasons may be because there are not many racialized Canadian nurse researchers, and non-racialized researchers may be reluctant to become involved in this type of research. I am particular concerned about this issue considering that the population of Toronto is comprised of approximately 36.8% visible minorities (Statistic Canada, 2001).

The vision and contributions of nurse leaders help to shape our healthcare system. As the researcher, I am confident that the current study will significantly enhance the sparse body of nursing literature on Black Canadian nurses, and shed light on the important perspectives of racialized nurse leaders.

Significance of the Research

This research endeavours to understand how differences based on race shape the experiences of racialized minority nurses employed in formal leadership and decision-making positions. In particular, it focuses on African Canadian female nurses with Caribbean backgrounds who have achieved leadership positions -- notwithstanding the

racial discrimination and prejudice in the workplace that generally thwart the advancement of non-White women to positions of authority.

Perhaps most importantly, this research provides the opportunity for the research participants to share their experiences as Black nurse leaders in a predominantly White female management workforce, and to give their perspectives on some of the major issues and barriers confronting them on a daily basis. Their stories speak to the racial discrimination embedded in healthcare structures (Henry & Tator, 2006), and reveal its negative effect on racialized nurses at all levels. These experiences, and indeed my own, are the references that frame this research.

Regarding the under-representation of racialized nurses in the upper hierarchy of nursing, it is a situation that must be remedied if our society is to genuinely reflect something more than diverse ethnicities inhabiting the same workspace. The ongoing practice of racialized minority nurse managers being limited to subordinate positions does little to utilize diverse capacities for the benefit of the health care organizations to better understand and serve diverse communities.

Resolutions to these problems are not easily found, as the aegis of race-based discriminatory practices in healthcare environments lies not with the marginalized, but with those who perpetuate the dynamics of inequality. But it is my belief that through this and other current research, we will gain a better understanding of the work experiences of Black Canadian women who have achieved leadership positions in nursing. Nursing and healthcare leaders will have a clearer picture of the impact of racism on the experiences of Black and other racialized minorities in nursing. In particular it is my hope that this research project can provide results that will initiate

national conversations on racism in nursing, and an awareness of the urgent need to dismantle exclusionary practices in the profession. In summary, my hope is that the findings of this research will enhance the understanding of the need for diversity at all levels in nursing, to better meet the needs of a rapidly growing ethno-racial population.

Situating Myself as Researcher

Part of our struggles is to be able to name our location, to politicize our space, and to question where our particular experiences and practices fit within the articulations and representations that surround us.

(Borsa, 1999, p. 36)

The foremost requirement of “an interpretative research process” is for researchers to “locate their own position on the nature of reality which helps us to understand what happens when we research, make sense of the data generated, and...the selection of...frameworks to guide our analysis” (Koch (1999, p. 21). Arber (2000) posits that researchers conducting qualitative research are expected to truthfully define themselves and identify the place from which they speak, and the ways in which they might affect or be affected.

As Daniel (2005) points out, “The researcher’s positioning can affect the questions that are being asked, the theoretical paradigms that are developed, and the interpretation of the research data” (p. 69). According to Daniel (2005):

Positioning...deals with the understanding of the material and social consequences or rewards that accompany the particular location or space that one occupies. For example, to name oneself...is in no way an indication that the researcher has engaged in an analysis and interrogation of the meanings inherent in occupying that location (p. 69).

It is important to acknowledge that my position in the research project as an African Canadian woman and registered nurse equips me to give context to the assertions, arguments and interpretations made. I concur with Daniel (2005), an African Canadian woman from the Caribbean, who posits that her subject location provides “a unique worldview” enabling her “to question and interrogate the manner in which Black women and the Black community has been represented” (p. 71).

Given this context, my history and experiences have undoubtedly informed my evaluation of persistent racism in professional nursing. My experiences as a child growing up in Jamaica were influenced by racist ideologies that attached a negative stigma to my Black identity. These experiences formed the basis for my critique of and resistance to Eurocentric hegemony in Britain, and later in Canada.

I emigrated from Jamaica to England at an early age, and have been domiciled in Canada for more than twenty years. While attending public school in Yorkshire, I recall being called ‘nigger’, and being told by White students to go back to Africa. The U.K., where I spent the early years of my career in the 1960s, was the destination for many Black women who emigrated from the Caribbean region, a number of whom worked as professional nurses. During this era, it was common for Blacks in British society to experience overt racism in all aspects of their lives.

As a nurse in the U.K., my experiences were marred by racial discrimination from White patients and their families, healthcare professionals and other workers. The vestiges of European colonialism and imperialism remain entrenched in British society, and continue to affect the daily lives of Black people. Against this background, it is reasonable to argue that national identity and inclusion in British society is exclusively

reserved for White people. Today, in Canada, my experiences of racism are not dissimilar to those in the U.K., although the discrimination is more subtle in nature.

During my professional nursing career, which spans over thirty years, I have been a front-line staff nurse, midwife, clinical nurse educator, prenatal educator and coordinator, and clinical nurse specialist, in various large teaching hospitals in the U.K., and Canada. Despite my academic qualifications and nursing background, I have not yet acquired a formal leadership position in nursing. I hasten to add that I believe my failure to obtain a management position is not because of my inability to function in the role, or because I have not stated to my supervisor that I aspire to leadership, but rather because of my racial identity.

As a doctoral student in the Department of Sociology and Equity Studies at the Ontario Institute for Studies in Education, I have had exposure to critical discourses and perspectives that confront racist epistemologies that marginalize racialized people. I am committed through this research study to authenticate the narratives of the racialized nurse leaders who are my subjects, and who voiced their discontentment and frustration with being discriminated against, silenced and marginalized in their healthcare workplaces.

One of the challenges I encountered in the early stages of this research project was not having adequate time to meet and discuss issues related to the research with my peers. For this reason, I turned to nursing colleagues to talk about my research ideas and concerns. However, I soon realized that most White nurses were simply not interested. Although somewhat disheartened by this, I remained determined to fully engage the subject. In my opinion, their negative attitudes may stem from their resentment of a

research topic that illuminates the dynamics of racial inequity and discrimination in the nursing profession.

This negative reaction from my colleagues did not come as a surprise, because Anglo-Saxon nurses typically refuse to acknowledge the reality of racism in the nursing profession (Hoff, 1994), and often adopt a colourblind stance. It is my contention that among White nurses, there is denial that the racism and discrimination embedded in many of Canada's healthcare workplaces have devastating effects on racialized nurses' quality of work life, health and wellbeing. Although many Black and other ethno-racial minority nurses were clearly pleased about the research, some doubted that the finding would generate substantial changes in their workplace environments.

The fact also remains that, as an African Canadian woman and nurse, my decision to focus on issues of race and racism in nursing may jeopardize my future career advancement. Yet, in spite of this possibility, I strongly believe my research is needed, and will not only make a significant scholarly contribution to the nursing profession, but will also help facilitate the changes needed to develop a more equitable workplace. For the most part, I am also hopeful that the study will inspire meaningful dialogue that will eventually improve racialized nurses' experiences in their healthcare workplace environments. To this end, I fully concur with Spratlen (1998) when she said:

There may well be discomfort and negative reactions associated with even raising the question of racism and racist practices within professional nursing. However, the benefits far outweigh such potential limitations. A frank and open exploration of these issues is preferable to a continued silence, lack of awareness, and acceptance of current processes and conditions (p. 8).

Researcher Insider/Outsider Position

The positioning of the research players, meaning the researcher and the research participants, is of paramount importance and cannot be overlooked when conducting research on issues related to race. The researcher's positioning as the one asking the questions in relation to the object of inquiry has to be examined carefully. The partisan nature of research places the researcher in a position of wanting to present a strong and convincing story to achieve their goal. In addition, the researcher's history, investments, and motives shape their interpretation of the research data and the methodology (Kamler, Reid, and Santoro, 1999).

Frequently debated among social science researchers is whether the researcher functions as an insider or outsider in the research process (Roberts, 2001). The notion of 'insider status' relates to the researcher sharing commonality with the research participants; that is, the researcher and the participants may come from the same racial background, and have similar opinions and perspectives on issues of race.

I believe that the fact that I am a Black woman and a registered nurse has been beneficial in the research process, and has eclipsed any possible limiting influences. At a superficial level, it may seem logical that a Black researcher is more suitable to conduct research related to race relations. One possible advantage is that interactions between Black researchers and Black participants are likely to result in shared meanings about racialized identity formation and cultural contexts that may not be possible with White researchers (Kamler et al, 1999). This argument can be validated by the fact that the Black researcher will most likely have a common history of experiences of discrimination and racism, and therefore has a better understanding of the participant's situation.

Based on the outlined argument, my membership in the community of Black nurses has given me access to the discourses of other Black nurses that may be unavailable to non-Black and/or non-nurse scholars. My combined social and professional positions give me an insider's view on several issues confronting Black nurses in the workplace. Through my insider position, I bring to the research multiple perspectives on the experiences of Black female nurses that enable me to theoretically position their voices in the centre of this research project.

Clarification of Terms Used in the Research

For purposes of this current study, the following definitions have been adopted.

1. *Registered Nurse* refers to an individual who has graduated in nursing from an accredited university or college, and is registered by the provincial College of Nurses as a "Registered Nurse".
2. *Visible minority* refers to persons other than Aboriginal peoples or those who are White. The visible minority population includes the Chinese, South Asians, Africans (Blacks), Filipinos, Latin Americans, Southeast Asians, Arabs, West Asians, Japanese, Koreans and Pacific Islanders (Statistic Canada, 2001).
3. *Black and African Canadian* is used inter-changeably throughout this study to describe people of African descent who self-identify as Black.
4. *Diversity* as used in this study refers to racial and ethnic differences.
5. *Ethno-racial minorities* refer to all ethno-racial groups.

6. *Nurse leader* is used in this study to refer to a registered nurse who holds a managerial or administrative position within a healthcare facility.
7. *Nursing leadership* is defined broadly to include professional roles and responsibilities and a degree of authority and power, whether formal or informal. For the purpose of this study, 'leadership positions in nursing' refers to supervisory and decision-making roles in nursing administration and management. These positions include nurse manager, nursing director, nurse executive, and nurse coordinator.
8. *Race* as a concept is defined in this thesis as a social construct and not used to refer to biological differences among people such as skin colour, facial characteristics and hair texture. Race as a social construction refers to contested systems of meaning used to justify the unequal treatment of certain groups of people, and benefits and privileges for other groups.
9. *Racialization* is here defined as "extend[ing] to people in general but also to specific traits and attributes which are connected in some way to racialized people, and are deemed to be "abnormal" or "less worth" (Ontario Human Rights Commission [OHRC], 2005, p. 9). The term racialized as described by the Canadian Research Institute for the Advancement of Women [CRIAOW] (2002) refers to "...anyone who experiences racism because of their race, skin colour, ethnic background, accent, culture or religion" (p. 2). In addition, It can be argued that dominant racist ideologies reinforce the process of racialization, and thus legitimize the marginalization and discrimination of

certain groups and people on the basis of “biological differences and or cultural differences” (Van der Valk, ¶. 18).

The CRIAW (2002) points out that:

Racialized women have different cultures, histories, religions, family norms, life experiences, and are subject to different stereotypes. What they have in common is they are *racialized* – they are subject to racism and made to feel different because of their racial/ethnic background (p. 2).

Organization of Thesis

The structure of this thesis is as follows:

Chapter One: Background and Introduction — This chapter provides an introduction to the research project and its origins, including an identification of the research problem and a description of the objectives and significance of the work. I ‘situate’ myself in relation to the research, and describe the relevance of my insider/outsider position within the context of the work. The final part of this chapter briefly explains the specific terms used in this study, outlines the content of each chapter and concludes with a summary.

Chapter Two: Review of the Literature - This chapter provides a review of the relevant existing literature related to the main issues around which the project is focused. The historical context of immigration, multiculturalism and the immigrant experience is outlined; and the notion of labour market diversity and the perceived benefits of workforce diversity are examined, along with the importance of a diverse workforce in healthcare organizations. Additionally, the chapter explores the racial prejudice and discrimination embedded within many Canadian workplaces, and the status of Black women in the labour market. The chapter then looks more specifically at the work experiences of Black women in the Canadian nursing profession, including the early

history, and the hierarchical structure of the nursing profession. The final part of this chapter provides a critical discussion of issues of race and racism in Canadian nursing, followed by a critical review of previous research projects on racialized women in Canadian nursing. The chapter concludes with a summary.

Chapter Three: The Theoretical Framework - Chapter Three opens with a discussion of the politics of race, and touches on racial stratification and discrimination. It also looks at the various types of feminism, including mainstream versus black feminism, and negative racially-based stereotypes of Black women. Chapter Three concludes with a detailed description of the elements of the theoretical framework --black feminism and integrative antiracism -- that underpin the research, as well as a summary.

Chapter Four: Research Methodology - This provides a detailed description of the study design, the research methodology adopted for the study, and the rationale for its choice. In particular, the chapter discusses phenomenology, highlighting the Van Manen's method of doing phenomenological research, and the rationale for the selection of the phenomenological method. The chapter also presents the qualitative research methods used for data collection and analysis, as well as discussing the ethical considerations pertinent to the study. An outline of the processes used for participant recruitment is included, as well as a brief profile of each of the study participants collated from their demographic/biographic data.

Chapter Five: Research Findings - This chapter reports the actual findings of the study under a number of thematic categories that emerged from the participants' responses.

Chapter Six: Data Interpretation - This is a qualitative analysis of the participants' narratives of their experiences. This chapter summarizes the themes that emerged from

the interviews. The findings are presented and discussed within the context of the literature reviewed in Chapter Two.

Chapter Seven: Summary/Conclusions - The final chapter offers the conclusions derived from the research, and an assessment of how this work contributes to the literature, as well as its implications for the nursing profession. Chapter Seven also identifies the limitations of this study, as well as offering suggestions for further research.

Summary

This chapter gives an introduction to and overview of the study, in particular a description of the study problem, objectives and significance. I explain how I am situated in the research, and define my insider/outsider position in relation to the study.

Finally, there is an explanation of specific terms used in the research, and a brief description of the contents of each chapter.

In the next chapter, I will present a review of the literature.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

The aim of the chapter is to review literature that is relevant to the study to gain insight and understanding of the research topic. This review serves to identify gaps in the existing literature on this topic, and reveal where further inquiry is needed.

To provide a framework for this study, this literature review is divided into the following major areas: Canada's policies on immigration and multiculturalism, labour market diversity, racial prejudice and workplace discrimination, the status of Black women in the labour market, the early history of Black women in Canadian nursing and racism in Canadian nursing.

Due to the focus of the present research, and to identify what is generally known about the impact of racial dynamics on the labour market, this chapter begins by broadly looking at the literature on Canada's policies on immigration and multiculturalism. A brief discussion on ethno-racial diversity in the labour market, particularly the relevance of a diverse workforce to healthcare organizations, follows.

Having looked broadly at the notion of diversity in the labour market, the second part of the chapter examines the impact of the racial prejudice and discrimination embedded in many Canadian workplaces. Unfortunately, these practices may also be seen in healthcare work environments, affecting the work lives of racialized nurses.

The third section in this chapter examines the status of Black women in the labour market, followed by a brief review of the early history of Black women in Canadian nursing.

The final section focuses on the discourse of race and racial prejudice in Canadian nursing, and the hierarchical structure of the Canadian nursing profession. The lack of data on race and ethnicity is revealed, followed by a critical analysis of the previous research on racialized women in Canadian nursing, with the focus on the history of Black Canadian female nurses. This sets the scene for an outline of the research objectives.

Historical Context

Any interrogation of racism in Canada must first begin with some understanding of Canadian immigration and multiculturalism policies and processes. The two are inseparable.

Immigration

Francis, Jones, and Smith (1988) posit:

The history of [Canadian] immigration since 1945 involves three closely intertwined elements: the federal government's immigration policy; Canadians' response to immigration and to the various groups of immigrants who have made Canada their new home; and the experiences of the immigrants themselves" (p. 398).

These issues are not peripheral to this study, but lie at its core. It is arguable that Canada has placed itself at the forefront of Commonwealth nations in promoting immigration policies that were fair and equitable to all Commonwealth citizens. Nevertheless, it has been suggested that Canada's immigration policies remained

discriminatory in many ways despite this leadership position. While many Anglo-Saxons favour liberal immigration policies and legal immigration into Canada, the views of others are that Canada's immigration system is too lax, and that some changes should be made to "... make entry more difficult for some than for others" (Winks, 1997, p. 436).

Over the years, there is little doubt that Canadian immigration policy has negatively impacted the entry of racialized nurses from the Caribbean into Canada. Calliste (2000) argued that Canada "create[d] and maintain[ed] segmented labour markets and the subordination of Black nurses...through differential immigration policies" (p. 150). Calliste (2000) further maintained that prior to the 1960s, the entry of Blacks into Canada was controlled by immigration policies so that:

...they were incorporated into the labour market - as free immigrant labour with citizenship rights, or unfree migrant labour -were structured by a dialectic of economic, political and ideological relations (the demand of employers for cheap labour and the state's desire to exclude Blacks as permanent settlers) (p.150).

She further explained that only a few Black nurses were allowed entry to Canada "under differential immigration policy" such that their employers had to be informed of their racial background (Calliste, 2000, p. 150). Those nurses who gained entry as "permanent immigrants" were required to be more qualified than their White counterparts (p. 150). Calliste, as cited in Calliste (2000), argued that, "This differential immigration policy helped to reinforce Black Nurses' subordination within a gendered and racially segmented nursing labour force" (p. 150).

The barriers erected by restrictive immigration policies obstruct the entry of racialized nurses from the Caribbean into Canada. And for those who do gain entry against all odds, the barriers erected by racism undoubtedly undermine their careers and their advancement in the profession. Furthermore, the bigotry and racial inequality in

Canadian nursing, at times difficult to detect yet increasingly difficult to ignore, result in very few of these Black nurses making it into leadership positions.

Although quite a bit more can be said about the history and evolution of Canada's immigration policies, it is clear that race and ethnicity played a key role in government decisions (Henry & Tator, 2006). However, the times would change, and ethnic diversity would become a growing reality as the multicultural Canadian landscape became 'coloured' with Black, Brown and Asiatic peoples. Canada's 2001 census indicates that nearly half of its citizens (47%) are of an ethnic origin other than British, French or Native-born Canadian. The sources of this ethnic diversity are documented in the reviewed literature. It can mainly be attributed to the large-scale international migration that followed changes in Canadian immigration policies and practices (Castles & Miller, 1998; Galabuzi, 2001).

Today, the Department of Canadian Heritage (2004) indicates that Canada's "...30 million inhabitants reflect a cultural, ethnic and linguist makeup found nowhere else on earth" (§. 1). As a result, multiculturalism is considered a fundamental value of Canadian society (Goldman, 2002). And yet, Goldman (2002) caution that "...multiculturalism is no longer an indicator of tolerance, pluralism and community" (§. 8).

Multiculturalism

Francis et al (1988) posit that:

In October 1971, Prime Minister Pierre Trudeau told the House of Commons that the government "accepts the contention of other cultural communities that they, too, are essential elements in Canada and deserve government assistance to

contribute to regional and national life in ways that derive from their heritages” (p. 412).

Thirteen years after Trudeau’s declaration, “...the federal government was [spending] more than \$23 million annually for its multicultural programme including aid to... heritage-language classes, and cultural festivals, and the preparation of histories of major Canadian ethnic groups” (p. 412). Thus was the recognition in Ottawa of the significance of multiculturalism to Canadian society. However, Francis et al (1988) also mention journalist Caitlin Kelly and her comment that, instead of keeping immigrants “singing and dancing”, the government should give attention to “real” problems of ethnic inequality (p. 414).

It is not only important to understand what multiculturalism is; it is also necessary to have an understanding of its implications for the current research study. The concept of multiculturalism provides an important context for the current study and critique of the nursing profession. To begin with, an analysis of multiculturalism in the “broader societal environment” is important to understanding the systematic oppression (Jamal, as cited in Dei & Johal, 2005, p. 226). In this section, I wish to highlight some of the contradictions of multiculturalism, and what it is purported to be in Canadian society (although it really isn’t). Daniel, as cited in Dei & Johal (2005), makes the important point that:

Multiculturalism, (the foundation theory upon which much of Canada’s treatment of diversity issues is built) fails to address the institutionalized and historical factors that inform the manner in which the society’s non-White citizenry is treated. The focus of multiculturalism remains rooted in the ideology that much of the conflict among diverse groups results from groups’ lack of knowledge of each other. Therefore, the focus has to be on providing positive stories and snippets of information regarding Canada’s diverse population (p. 67).

Francis et al (1988) noted that “The federal government’s multiculturalism policy announced in 1971 gave ethnic groups an official status they had not previously enjoyed, and served as recognition that Canada, in one century, had become a multi-ethnic and multicultural society” (p. 398). However, the inescapable fact is that multiculturalism is not restricted solely to what is espoused in the rarefied world of politics, but is also reflected in what is played out daily in the socio-economic lives of marginalized citizens and, specific to this thesis, Black female nurse managers.

In the context of Canada’s pluralism and the issues examined in the current research study, the notions of diversity and multiculturalism are important in the future of nursing. Achieving social cohesion and the elimination of racism and discrimination in Canada’s pluralistic society and workplaces, including healthcare environments, “...requires more than constitutional measures and legislation” (Department of Canadian Heritage, 2004, ¶. 5).

There has to be a willingness among members of the White dominant culture to acknowledge that issues related to race and ethnicity create barriers and inequalities for racialized minority groups in Canada. Most importantly, inequalities must be addressed “...if all Canadians are to enjoy the same sense of belonging and attachment to their country [Canada].” (Department of Canadian Heritage, 2004, ¶. 21).

Although Canada is often perceived to be a mosaic of ethnicities blending into a seamless multicultural landscape, little could be farther from the truth. As Bedard (2000) points out:

Multiculturalism is a narrative that defines Canadians as different from the United States... [which] uses the analogy of the “melting pot”; Canada is analogous to the “tossed salad” or “mosaic.” But imbedded (sic) in the multicultural narrative

is the belief that we as Canadians are not as racist as the citizens of the United States; we are sometimes referred to as non-racist (p. 48).

Canada has taken great pride in this perception, promoting itself as one of the most ethnically diverse societies in the Western world and a leader in human rights practices (Moore, 2001; National Anti-Racism Council of Canada, 2007; Omidvar & Richmond, 2003). The diversity is unquestioned; it is quantifiable by numbers. One may argue that either implicitly or explicitly, the political face of multiculturalism is deceptive, hiding an inherent agenda that foments segregation.

There is multiculturalism rhetoric of advancing tolerance for ethno-racial and cultural differences embedded in dominant discourses. But it is not a true reflection of the everyday experiences of racial inequality and discrimination for many racialized groups and Aboriginal people living in Canadian society (Saloojee, 2003). These experiences disprove the common misconception that racism is no longer present in our society.

Thus we must question whether multiculturalism as practiced or promoted in Canada truly works, or indeed is intended to work. Das Gupta (1999) remarked, "Demographic heterogeneity does not automatically imply the success of a multicultural policy" (p. 191). Also, Das Gupta (1999) notes "Various multicultural policies have circumvented the issue of power relations [so that] in practice, cultural and linguistic principles...focus on the attitudinal part of discrimination rather than on structural barriers" (p.192). These structural barriers, salient to this study, go beyond language and culture, and are implicit in racist practices directed against non-Canadians. This is evident in diverse workplaces, and the socio-economic complexity, however much ignored by those who refuse to recognize that non-ethnic groups suffer the brunt of

discrimination, is very real and considerably entrenched. It is considerably entrenched, and the socio-economic complexity is very real. Mensah (2002) posits that:

Increasingly Blacks and Whites are living in two separate societies (at least in spatial terms) in Canadian cities such as Toronto... With only minimal ties to high- or White society -- as friends, neighbours, club members, co-workers, and acquaintances -- many Blacks effectively are disconnected from the personal networks through which job information, especially on the most desirable and well-paid positions, is disseminated (p. 168).

While the presence of various ethnicities gives the appearance of a multicultural society, when it comes to equity issues, there is a sharp divergence between the experiences of these ethnic groups and mainstream society. It can be argued that the main problem with Canada's policy of multiculturalism is that it is workable in theory, but in actual practice it leaves much to be desired. Unquestionably, multiculturalism in Canada is fraught with contradictions and complexities. Despite being well-intentioned, it has done little to resolve the perceived socio-economic disparities between Anglo-Saxons and non-White Canadians, and in fact may have contributed to them.

The Immigrant Experience: Great Expectations and Harsh Realities

The observation has been made that migrants' decisions to leave their homelands are/were based on complex and varied reasons (Galabuzi, 2001). These include economic reasons, the desire to join family members and, for some, to escape human rights abuses and political turmoil (Omidvar & Richmond, 2003).

It stands to reason, therefore, that immigrants to Canada, particularly those from racialized groups anticipating a better life for themselves and their families, naturally expect(ed) the Canadian way of life to be free of racism and other forms of inequalities and discrimination (Crawford, 2004). However, once on Canadian shores and attempting

to pursue their dreams of prospering and realizing a better life, many of them are often confronted by barriers based on a number of factors including lack of ability or lack of education, language, lack of recognition of foreign credentials, race and ethnicity, etc. The typical reality faced by immigrants frequently becomes one of frustration and disillusionment. As Saloojee (2003) indicates, discrimination and bias are entrenched as inevitable constructs of a glass ceiling where institutionalized inequities occur at virtually all societal levels:

Racial inequality and discrimination are both the product and the confirmation of power imbalances in society; as well, they are a function of structural constraints that are rooted in the fabric of society. These structural constraints operate in such a way as to disadvantage members of racialized minority communities as they access the labour market and as they seek to advance in organizations (p. 4).

Labour Market Diversity

Muller & Haase (1994); Marquand (2002); Ivancevich & Gilbert (2000) make the point that over the past several years many large organizations in Western societies have begun to focus attention on the levels of ethno-racial diversity in the workforce. It has been suggested that when healthcare organizations are compared to other workplaces, they have been much slower in embracing diversity. Marquand (2002) contends that in more recent years healthcare executives are recognizing that "...having a culture that values diversity would give them a competitive edge" (p. 1). In fact, the literature shows a diverse workforce is critical to the success of organizations (Comer & Soliman, 1996). Marquand (2002) states: "Creating workplaces that value diversity isn't just about doing the right thing – it also makes good business sense" (p. 2).

Lee (1999) asserts that "...an inclusive working environment enhances an individual's sense of belonging and worth" (p. 16). He further notes that organizations

practicing diversity awareness are able to “recruit, retain and develop people without the fear of being found guilty of discriminatory practice” (p. 16). Lee (as cited in Dreachslin, 1999, p. 431) states, “...diversity entails revisioning differences, essentially moving from legal compliance to valuing diversity, from tolerance to respect, from challenge to opportunity.” Jassamy (1997) suggests that even though leaders in some organizations are aware of insufficient ethno-racial diversity at various levels within their own organizations, nevertheless are reluctant to confront the issue because they fear drawing attention to problems related to race and racism.

On the basis of the review of nursing and healthcare literature, there is little doubt that the issue of ethno-racial inclusiveness has firmly emerged as an essential component in healthcare delivery. Similarly, Aries (2004) argues that, “Diversity has become a pressing issue in the delivery of healthcare” (p. 172). Coffman et al (2001); Dreachslin (1999); Dreachslin, Hunt, and Sprainer (2000); Dreachslin, Simpson, Sprainer, and Evans Sr (2001); Jessamy (1997); Wallace (1996) clearly conclude that for healthcare delivery organizations to remain viable in an intensely competitive healthcare environment requires the concerted efforts of healthcare leaders to embrace workforce diversity at all levels.

Weech-Maldonado, Dreachslin, Dansky, De Souza, and Gatto (2002) posit that healthcare leaders should focus their efforts on increasing minority groups’ representation to reflect the changing demographics of today’s society. To provide ethno-culturally competent and appropriate care to all people from a wide range of ethno-racial populations necessitates having health care providers from diverse ethno-cultural groups (Abrums, 2001). According to Abrums, (2001), “culturally competent care,” also cited as

culturally based care, is “sensitive to issues related to culture, race, gender, and sexual orientation” (p.270).

Implicit in the above comments is a firm recognition that not only does a lack of diversity negatively impact healthcare staff, but that there can also be negative consequences on the quality of care delivered to those clients who increasingly come from a ‘minority’ demographic (Jackson, 1998). Authors such as Reynolds (2004); Robertson (2005); Weech-Maldonado et al, (2002) observe that members of diverse populations receive less than acceptable quality healthcare for a variety of reasons. Reynolds (2004) points out that healthcare organizations and providers are “...facing challenges addressing the needs of patients from varying cultural and ethnic backgrounds” (p. 238).

Interestingly, healthcare facilities for many years had ascribed minimal importance to patients’ perspectives about their own healthcare. However, in the present era of patient and family-centered care, most healthcare organizations and facilities have transformed their approach and are now asking patients for their opinions about the treatment and care they receive. It is widely acknowledged in nursing and healthcare literature that patients’ levels of satisfaction about care and services are based on cultural attitudes, beliefs, preferences and expectations (CNO, 2004). Additionally, the nursing and healthcare literature indicates that culturally-based healthcare plays a significant role in patients’ perception and evaluation of their healthcare (RNAO, 2007). In light of this, Aries (2004) argues that healthcare providers have to be knowledgeable of the ways in which “culture... influences care giving and the significance of...being culturally competent caregivers” (p. 174).

The RNAO (2007); Cortis (2003); Reynolds (2004) argue that understanding and respecting the cultural practices of diverse populations can improve interactions between these populations and their health service providers, and positively impact their health outcomes. Reynolds (2004) emphasizes that healthcare organizations are responsible for ensuring that the care and services provided to patients comply with culturally appropriate standards. Although a significant body of research literature recognizes that cultural context influences health beliefs and behaviors (RNAO, 2007), healthcare in developed countries continues to be greatly influenced by “Western middle class values and beliefs” (Beishon et al, as cited in Cortis, 2003, p. 62).

Aries (2004) and Dreachslin, Sprainer and Jimpson (2002) suggest that increasing diversity at all levels of the healthcare workforce is required in order to change current healthcare delivery practices that are greatly influenced by the dominant culture, and that such change is essential to meeting the needs and expectations of diverse populations.

There is also strong evidence that a diverse healthcare workforce, at all levels, offers different perspectives and strategies to meet the needs of a diverse population (Aries, 2004; Etowa, 2007; Etowa, Foster, Vukie, Wittstock, and Youden, 2005). On the other hand, predominantly Anglo-Saxon workforces, particularly at management levels, generally result in decisions and services that are influenced by dominant perspectives and values (Dreachslin et al, 2002).

Dreachslin (1999) argues that not only should healthcare delivery organizations respond to demographic changes in the population, but they should also assess their strategic positioning against best demonstrated practices. Dreachslin proposes the

following five-part framework as a guide toward achieving a diverse workforce within healthcare organizations:

1. **Discovery:** This aspect should embrace emerging awareness of racial and ethnic diversity as a significant strategic issue.
2. **Assessment:** A systemic review of organizational climate and culture vis-à-vis racial and ethnic diversity should be undertaken.
3. **Exploration:** Institute systemic training initiatives to improve the health services organization's ability to effectively manage diversity.
4. **Transformation:** This would reflect a fundamental change in organizational practices, resulting in a culture and climate in which racial and ethnic diversity are valued.
5. **Revitalization:** Renew and expand racial and ethnic diversity initiatives to reward change agents and to include additional identity groups among the health services organization's diversity initiatives (1999, p. 429).

Dreachslin's (1999) framework has significant implications for healthcare organizations and the healthcare system in general. Hence two chief objectives of this study is to highlight and bring attention to the lack of racial and ethnic diversity in nursing leadership, and to identify the challenges faced by racialized minorities in leadership positions. The concerns raised in this study related to the lack of accurate and accessible data on the ethno-racial composition of the nursing workforce, and the pressing need for professional associations for nurses to collect ethno-racial data on the nursing workforce, are also supported by Dreachslin's framework. Undoubtedly, this research study is timely and a starting point to opening the dialogue on race issues in

nursing and healthcare in general that may bring about change for racialized Canadian nurses.

Racial Prejudice and Workplace Discrimination

As mentioned elsewhere, racism and racial discrimination continue to be a part of the fabric and tradition of Canadian society (Henry & Tator, 2006). However, the literature also contains conflicting viewpoints about issues of race in our society. On the one hand, the picture is painted of a multicultural and multiracial society, and everyone lives and works harmoniously with each other. On the other hand, according to Dovidio & Gaertner (2005), the blatant racism and other discriminatory practices that were once prevalent in contemporary societies have been replaced with subtler manifestations of prejudice.

The literature I reviewed shows that individuals may experience racism in myriad ways. Law, Phillips and Turney (2004) contend that, "Racism takes different forms in different settings" (p. 96). According to Essed (1991), "Racial discrimination includes all acts -- verbal, nonverbal, and paraverbal -- with intended or unintended negative or unfavorable consequences for racially or ethnically dominated groups" (p. 45). Henry & Tator (2006) content that the nature of racism is elusive and ever changing. Over the past several years, the more blatant manifestations have been replaced with subtle and more complex forms of racism and discrimination, which are more difficult to recognize and deal with (Dovidio & Gaertner, 2005; Fernando, 1996; OHRC, 2005). Of particular interest, Kennelly (1999) argues that the subtle nature of recent forms of racism and prejudice are "more dangerous than outright slander because they are hidden within the

rhetoric of ‘logic’” (p. 169). It has been widely recognized that, even if the manifestations of racism and other discriminatory acts are subtle in nature, the impact is devastating for the recipient.

We also should recognize that institutional racism and racial discrimination are not new. Karisen & Nazroon (2002) describe institutional discrimination as discriminatory policies or practices embedded in organizational structures; therefore, it tends to be more invisible than. Research studies provide ample evidence of everyday occurrences of discrimination and inequalities based on ethno-racial, gender, and class differences in many workplaces in Canada, the U.S. and the U.K. (Berdahl & Moore, 2006; Browne & Misra, 2003; Canadian Race Relations Foundation, 2000; Chima & Wharton, 1999; Deitch et al, 2003; Dickerson, 2002; Fernando, 1996; Omidvar & Richmond, 2003). Although literature about workforce diversity has increasingly engendered heightened awareness about the value of a diverse workforce, discrimination based on ethno-racial differences continues to plague many workplaces in Western societies. In Saloojee (2003) words:

One of the pervasive myths is that since members of racialized groups are found in the workforce there is no widespread discrimination to their entry into the labour force. Once they enter...they encounter the “glass ceiling” an invisible barrier which prohibits their upward mobility within the workplace/organizational hierarchy and perpetuates inequality in the workplace (p. 6).

Mensah (2002) also pointed out that:

...given that racism is widespread in the workplace, is it not reasonable to infer, as did Ezorsky (1991: 23), that the practice of hiring, evaluating, and promoting workers through such vague and subjective concepts as ‘fitting in’, ‘personality’, and ‘vigor’ opens the door for racial biases? Having said that, it is only fair to acknowledge that Blacks in positions of power can use these same subjective indicators to further their personal biases not only against Whites, but also against other Blacks in the workplace. But when all is said and done, the relative impact of this practice would be far more devastating on Blacks than on Whites, given

the power imbalance between the two groups in a typical Canadian work environment (p. 169).

Within the context and content of this study, any scenario where personal biases impact workplace relationships applies solely to Whites, as Blacks have yet to scale the ladder to positions of power.

Ample evidence gathered over the years suggests racial prejudice and institutional discrimination embedded in the Canadian labour market have a negative impact on the work lives of many non-White Canadians (Galabuzi, 2006; Henry & Tator, 2006). The literature suggests that while many employers may not intend to carry out racist practices; nearly every workplace in Canada has practices and systems that discriminate against racialized minorities. Research shows that Canada's healthcare workplaces are not exempt from institutional racism because of a deeply entrenched system of dominance (RNAO, 2007). This way of doing business has come to be seen by many Canadians as natural and acceptable.

Undoubtedly, people who experience racism directly, process those experiences differently than those who are not confronted with racism. As evident from Henry & Tator's (2006) comment, "...racism is sometimes visible only to its victims. It remains indiscernible to others, who therefore deny its existence" (p.17). Indeed, the OHRC reported that 73% of all discrimination cases occur in Canadian workplaces (National Anti-Racism Council of Canada, 2002). The Commission further reports that 30%-40% of complaints made each year to the Commission are related to race and related grounds (OHRC, 2005). As Glass (1999) said: "Workplaces are socially constructed in ways that define who will and will not be able to comfortably work in that setting" (p. 420) In this context, research show that because of racism and racist ideologies, many racialized

minorities face formidable barriers to workplace advancement "...through stereotypic portrayal and representation" (Elabor-Idemudia, 1999, p. 38).

The Status of Black Women in the Labour Market

There is evidence in the literature indicating that researchers are starting to focus more attention on everyday racial discrimination and prejudice in the workplace as a result of the increased workforce diversity in most contemporary societies (Deitch et al, 2003).

Robinson (1999) points out that "Each of us has multiple identities that compose our lives. Included are race, gender, class, sexual orientation, ability, and disability" (p. 73). Murrell & James (2001) contend that these aspects of identity "...are inextricably linked" (p. 243) and have been shown to create different experiences and myriad forms of discrimination for racialized women in the work environment.

As discussed earlier in this work, a number of scholars have made the point that sometimes it's not only about race. For Black women in the workplace, it's hardly ever 'only' about race. It's about the combination of race, gender and class, and how the intersectionality of these two or three factors influences the work lives of Black females (Browne & Misra, 2003). However it is important, as a point of clarification, to note that the present study focus primarily on race.

Historically the impact of structural discrimination and racism in the labour market affects the status of Black women in the workplace environment. Elabor-Idemudia (1999) posits that:

The sexual division of labour within the market economy exists within a racist division of labour, which disproportionately locates Black women within racial ghettos. Women's work in the market economy, be it secretarial or service work, is hierarchically ordered by race (p. 40).

Hughes & Dodge (1997), among others, argue that even though work is a significant aspect of Black women's lives, little is really known about their experiences. A review of the literature shows that labour market research provides scant insight into Black female workplace realities, their perceptions regarding their job quality, or any other factors that likely influence their job (dis)satisfaction.

Nonetheless, a qualitative study done in the U.S. by Hughes & Dodge (1997) examined "African American women's occupational experiences -- their exposure to racial bias in the workplace" (p. 584). They found that "institutional discrimination and interpersonal prejudice diminish job quality" (p. 585), and revealed that exposure to these forms of racial bias was a more important predictor of quality of work life, "...than were other occupational stressors such as low task variety and decision authority, heavy workloads, and poor supervision" (p.581). Hughes & Dodge (1997) also noted that participants in the study who worked in "predominately White work settings" were more likely to report experiences of racial bias in the workplace (p. 581).

The literature further suggests that despite sweeping changes in contemporary labour markets, many professions continue to remain stratified by race and/or gender. The impact of racial ideologies, negative stereotypes and consequent assumptions regarding race and class identity are reflected in restricted job prospects for racialized women (Brand, 1999).

Hughes & Dodge (1997); James (1999); Sanchez-Hucles (1997) concur that only a limited set of professional occupations are made available to women of colour,

particularly Black women. As Elabor-Idemudia (1999) points out, “Racially-constructed gender ideologies and images often portray Black women as “naturally” suited for jobs in the lowest stratum of a labour market segmented along gender lines” (p. 40).

Collins (2000) maintains that the types of jobs Black women continue to access and perform are testament that their freedom from enslavement has not translated into their liberation from a life of servitude. A salient example of this is witnessed in research findings that clearly indict discriminatory practices in the labour market as contributing to the overwhelming concentration of working-class Black women in the service sector of the general labour force. Their numbers are to be found in the lower ranks of healthcare workers as nursing assistants, and in private households as domestics and companions to the elderly (Brand, 1999; Das Gupta, 1996). However, despite race-based parameters across diverse job spectrums, recent research suggests that educated middle-class Black women have benefited from growth in professional service occupations, and by and large are heavily concentrated in nursing, teaching, and social services professions (Amott and Matthaei, 1996; Cherry, 2001; Das Gupta, 1996; James, 1999).

Cherry (2001); Collins (1990, 2000); Das Gupta (1996, 2002); Maynard (2001); Maume (1999) suggest that despite Black women’s educational attainments, their experiences at work reveal patterns of racism and sexism. The interconnections of class, race, and gender continue to foil Black women, so much so that they are afforded limited opportunities for advancing their careers in the workplace hierarchy (Murrell & James, 2001). It is essential to recognize that anecdotal as well as research-based evidence suggests that the career opportunities and experiences of Black and White women in the workplace are significantly different.

Within racialized and gendered discourses, a variety of interpretations are conveyed within the ideological functions of white 'femininity' and black 'femininity'. It can be argued that the premise of femininity is fundamentally class consciousness. It has become increasingly clear that class differences have a strong direct effect on labour market opportunities. On this point, Brand (1999) argues that the social constructions of white 'femininity' and black 'femininity' determine each woman's place in the labour market because "ideological forms of femininity are race specific" (p. 86). She further suggests that because the notion of 'femininity' is racialized and socially constructed according to Eurocentric values and beliefs, Black women are socially perceived as incompetent, lazy and physically tough, and thus suited for lower-status positions and poorly paid manual jobs. On the other hand, the social construction of white 'femininity' lends itself to preferential treatment for non-racialized (White) women in the labour market because they are perceived as being fragile and inept for manual jobs, but intelligent and competent to take charge over other women, particularly racialized women. Hence, there is evidence that Anglo-Saxon women hold a disproportionate share of the high-level positions as supervisors and managers, and other roles exerting relative dominance, when compared to racial minority women (Brand, 1999; Marshall, 1996).

Berg, as cited in Kennelly (1999) argues that "stereotypes, both negative and positive, influence the thinking and decision making of employers" (p. 171). Kennelly (1999) makes the statement that, "stereotypical thinking forms the basis for rationales about why members of their workforces [are] hired, fired, promoted, or paid better" (p. 172).

Kennelly (1999) studied White employers in Atlanta in the U.S. to gain an understanding of the images they have of Black female employees. The study indicated that the majority of White employers ascribed negative connotations to Black workers based on racist stereotypes. Accordingly, Black female employees were characterized as single mothers regardless of their actual status, and were labeled as frequently late or absent from work, uneducated, lazy and lacking motivation and appropriate work ethics. Kennelly further reported that many employers who participated in the study acknowledged they stereotyped their Black employees generally as trouble-making, belligerent and argumentative. The employers also thought of Blacks as an annoyance because they tend “to complain and cause problems” by making claims of discrimination (p. 169).

Hagey et al (2004) theorize the problem of backlash for broaching issues of systemic racism and discrimination in nursing. Evidence from Hagey et al (2001) study suggests that there is a silent practice in healthcare organizations of paying out millions of dollars in settlements to nurses in discrimination cases in Ontario. Because of the practice of paying off complainants to remain silent, there is no public scrutiny of systemic racism and discrimination against racialized nurses in healthcare facilities. Thus we see how causal factors (workplace discrimination and negative stereotypes) and reactions (lack of motivation, claims of discrimination) are engineered and twisted through the employers’ racist lens to somehow justify castigating and maligning the victim, while their own culpability in perpetuating falsities and workplace inequities is brushed aside. There are no valid methodological or epistemological justifications for racial prejudice and discrimination.

The Early History of Black Women in Canadian Nursing

I have said earlier that the research literature on racialized Canadian nurses is extremely limited. This conclusion arises because after a comprehensive and intensive search of various electronic nursing databases, and nursing and other research journals and textbooks, very little literature could be found.

When compared to the substantive nursing research literature on Black nurses' experiences of racial prejudice in healthcare workplaces in Britain and the U.S., similar research in Canada is meager and begs the question: Why have scholars given little attention to Black women in Canadian nursing?

Chancy (1993) writes that "...Canada has had an uncomfortable history of denial and erasure when it comes to the history of Black people..." (13). Consistent with this view, Cooper (2000) argues that the contributions of Black people in contemporary societies have been largely ignored and excluded from mainstream history.

In the nursing context, it can be argued that for many years the contributions and experiences of Black nurses have been left out of the annals of Canadian history. As Barbee (1993) notes, "Racial bias in nursing is demonstrated in the almost total absence of Black nurses' contributions in nursing texts" (p. 346). Similarly, Flynn (2003, 2008) also acknowledges a dearth of historical accounts on African Canadian nurses available to the reading public. As Calliste (1993) points out, Canada's nursing literature is silent on Black nurses until the 1950s when small numbers started immigrating to Canada from the Caribbean. Cooper (2000) writes, "Black women in this country [Canada] have made history and therefore do have a history. This history must be constructed and made available if we are not to become victims of amnesia" (p.39). It is noteworthy that

because of a lack of original source material and transcripts related to the history of Black women in Canadian nursing, I had to use secondary sources in this dissertation. The limited historical literature on Black female nurses underlines the fact that their history has been a long, arduous struggle against racial inequality and discrimination in their chosen profession. It wasn't until the 1940s that Canadian hospital nurses' training schools were opened to Black women. At that time only well-educated women were accepted (Calliste, 1993).

Because of the resistance in Canada to accepting Blacks in hospital training schools, many Black women who desired to become nurses immigrated to the U.S., where Blacks have been accepted into nursing schools since the 1890s (although the southern states remained segregated until the 1930s) (Flynn, 2008).

Calliste (1993) recounts how racial discrimination in Canadian nursing in the early 1940s became public knowledge when the Halifax Children's Hospital in Nova Scotia refused a Black woman admission to the school of nursing. The Black community protested the segregation and racial discrimination in hospital training schools, and the resulting extensive media coverage caused negative publicity for the hospitals. Calliste (1993) further mentions that subsequently "the Children's Hospital in Halifax, Nova Scotia, accepted two Black students: Ruth Bailey from Toronto and Gwen Barton from Halifax" (p. 92). These two 'pioneers' passed the Registered Nurse (RN) examination in 1947 (Nursing History Digitization Project, 2006), but on graduation, they were not guaranteed employment in hospitals in Halifax.

It is also mentioned that other hospitals, including Victoria General Hospital and Grace Maternity Hospital, began enrolling Black nursing students in the mid-1940s

(Nursing History Digitization Project, 2006). Around the same time, St. Joseph's Hospital in Ontario accepted a Black woman named Marisse Scott to the school of nursing.

Not surprisingly, many Blacks in nursing reported experiences of blatant discrimination from colleagues, and patients and their families, while they were completing their training. Anecdotal accounts and the current research-based literature suggest that little has changed in Canadian nursing to improve Black nurses' experiences in healthcare workplaces (Collins, 2004; Das Gupta, 1996, 2002)

Racism in the Canadian Nursing Profession

Although Canadian nursing research in this area is limited, there is clear evidence in the literature to suggest that racialized nurses experience some form of race-based discrimination, harassment and inequality within their work environments (Calliste, 1993, 1996, 2000; Collins, 2004; Das Gupta, 1996, 2002; Hagey et al, 2001; McPherson, 2006; RNAO, 2007). Calliste makes it clear that some of the disparities experienced by Black female nurses are institutionally based:

Healthcare institutions reinforce the marginality of Black nurses by denying their experiences of racism. Instead they focus on interpersonal dynamics such as "communication skills" and "personality problems," and blame Black nurses for "their problems" rather than investigate the issue of racism (Doris Marshall Institution and Arnold Minors and Associates 1994; interviews, March 30, June 24 and July 3, 1996), as cited in Calliste, 2000, p. 159.

A critical analysis of the research data also reveals how the racism denied by healthcare institutions contributes to dramatic differences in the nursing experiences of Black and White women (McPherson, 2006), where the former are disadvantaged and the latter advantaged, particularly when it comes to attaining nursing leadership positions.

Even in an era of advancing workplace equity, research findings show pervasive ethno-racial inequality in Canada's nursing workforce, with Anglo-Canadians being more successful at being hired and promoted into leadership and managerial positions than are minority nurses. Collins (2004) suggests in her unpublished doctoral dissertation, that senior level positions in the nursing profession in Canada are commonly filled by White, middle-class women.

Given the focus of the present research study, having an understanding of the hierarchical structure in nursing will shed some light on the plights of the many Black nurses who are unsuccessful at advancing up the career ladder, and the few who do against great odds.

Anecdotal accounts and the nursing literature suggest that professional nursing in Canada, the U.K., the U.S., and other developed Western countries is structured with relatively small numbers of managerial roles (Wong, 2004), limiting the promotional opportunities for staff nurses involved in bedside nursing. Current trends indicate that few staff nurses will ever have the opportunity to advance into senior and middle management nursing positions.

Of the nursing managerial positions that do exist, there are various roles, with corresponding accountability and responsibilities, in most healthcare institutions. Furthermore, Patrick & White (2005) express the view that "The scope of nursing leadership roles is constantly expanding and evolving" (p. 200). There also seems to be considerable variation in the classification of these roles, which include managers, nurse administrators, directors of nursing and nurse executives (Donner & Wheeler, 2004).

Commonly, a nurse executive is positioned at the most senior level of the nursing hierarchy, and is generally identified as the vice-president of nursing or chief nursing officer. The nurse executive, functioning in a senior management role, participates as a member of the executive management team, and has responsibilities that include providing corporate leadership and support to the development of professional nursing practices across the organization (Ameigh, 1996; Davidson, 1996; Hemman, 2000).

The director of nursing is a middle-level management position with accountability to a nurse executive. The responsibilities of the director include overseeing nursing services across several patient care units, departments, programs and/or services.

The nurse manager is a first-line management position that in some facilities may be identified as nurse administrator. The nurse manager is accountable to a director of nursing, and has supervisory authority over clinical nurses and clerical and service staff in a designated patient care unit and/or department. Other responsibilities of the nurse manager include fiscal, human and equipment resource management to ensure the smooth operation of patient care services. No other role makes a more direct impact on the care and services for patients and their families (Fontaine, 2003). The nurse manager's position is usually the initial managerial slot open to staff nurses who desire to advance to management.

For the most part, it can be argued that formal nursing leadership roles and matching responsibilities are associated with the benefits of higher professional status, an increased salary and a more stable work schedule (generally Monday to Friday), when compared to the position of staff nurse. Although there are many challenges associated with working in management, it comes as no surprise that aspects of the formal

leadership roles in nursing -- such as setting the vision and goals for the department of nursing, overseeing patient care services and programs, ensuring the accountability of staff and fostering an environment conducive to professional practice and the delivery of safe patient care -- motivate many Black staff nurses to aspire to formal leadership positions.

The management literature indicates that racial and ethnic minorities in general are in limited numbers in managerial and leadership positions (Bravette, 1996), and because of race differences in authority attainment, minorities in managerial positions have less authority than Whites (Smith, 2002, Marshall, 1996). The under-representation of racial minorities in leadership and decision-making positions may in part be due to widely held negative stereotypes about racialized people. These stereotypes perpetuate a belief that minorities -- Blacks specifically -- are incapable of sound management decisions, so much so that they are not considered suitable for "...better paid, secure, more desirable jobs" (Das Gupta, 1996, p. 15). Murrell & James (2001) contend: "Misconceptions and negative attitudes...have been shown to derail the careers and success of women in the workplace" and "have a clear and negative impact on members of other racial and ethnic groups" (p. 244).

Collins (1997) believes that although Blacks have gained access into institutions they have languished at the bottom of the "managerial hierarchy," and as a result have been unsuccessful making "inroads into key decision-making positions and in the racial redistribution of power" (p. 55). Bell & Nkomo (2001) assert that the careers of women of African descent are commonly hindered by race discrimination in the workplace.

Martin (as cited in Van Dyke, n.d.) made the point that “for many minority professionals, there’s not just a glass ceiling at the top, it’s more a cement ceiling” (p.1). Golden (2002) states: “...many White women encounter a glass ceiling as they move up the corporate ladder. But for Black women, that ceiling is concrete” (¶. 5). The ‘concrete ceiling’ phenomenon based on race discrimination in the workplace environment prevents many racialized minorities from moving up in the management hierarchy (Bell & Nkomo, 2001). Both ‘glass’ and/or ‘cement/concrete’ ceilings are problematic, placing advancement beyond the reach of minorities regardless of whether they have attained the necessary academic qualifications and acquired job experience. Within the nursing profession, the general exclusion of Black women from managerial positions points to a hierarchal homogeneity based on race whereby White nurses occupy the pyramid’s apex.

Nestel (2000) points out that according to the 1991 Census, proportionately fewer visible minority nurses make it into managerial positions in Canada than do their White counterparts. Similarly, Spraten (1998), Marshall (1996) and Schmieding (2000) have indicated that nurses from racialized groups in the U.S. are also significantly underrepresented in formal leadership and decision-making positions in healthcare organizations. Spratlen (1998) further suggests that many African American nurses stay as staff nurses, and are never promoted or encouraged to pursue advanced educational opportunities (p. 7).

In a similar vein Van Dyke (n.d) argues that in spite of the ethno-racial diversity of the U.S. population, many racial minority nurses encounter racial barriers that prevent them from accessing senior level jobs in many healthcare facilities. Hakesley-Brown &

Malone (2007) note: “Lack of an infrastructure to support the development of Black leadership throughout the UK is a barrier to Black nurses excelling within the new and old NHS,” adding that “nurses in the US and UK still struggle with their invisibility and questions from the dominant culture concerning their legitimate power to be a nurse” (p. 12).

Schmieding (2000) presents the view that under-representation of racialized nurses in senior level positions has significant implications for the delivery of quality healthcare. She further suggests that increasing the representation of racialized nurses at senior levels within nursing is one of many ways to increase the recruitment of individuals from racialized groups into the profession.

Based on a review of Canadian nursing literature, it is obvious that little attention has been directed specifically to the work experiences of racialized nurses in formal leadership and decision-making positions in Canada’s healthcare workplaces. It would appear that in the case of African Canadians, their under-representation in nursing leadership positions and their experiences of racism in the workplace environment have gone largely unaddressed by nursing and healthcare leaders. Mateo (2001) offer the opinion that “Since the vast majority of personnel in healthcare institutions provide direct patient care through teamwork, attention must be given to the fact that the under representation of minority nurses in leadership positions is particularly troublesome” (p. 11).

It is my belief that the disparity in the ethnic and racial composition of Canada’s nursing leadership workforce requires direct attention and drastic change to meet the healthcare needs of Canada’s diverse ethno-racial population.

Canadian Nursing Workforce: Lack of Data on Race and Ethnicity

It is important to reiterate that this study attempts to expose the hypocrisy within the Canadian nursing profession. This is the profession that pays lip service to valuing and embracing notions of diversity, inclusiveness, equity and fairness to the fullest, and at all levels of nursing. The profession that while espousing these values as inherent characteristics of nursing does not address the reality of race and racism within.

It is reasonable to suggest that the ethno-racial composition of the Canadian nursing leadership workforce is not at an acceptable level of representation of the general population. Given this observation, which arguably is also noted by others in our society, there is definite cause for concern in view of the documented benefits -- such as improved patient satisfaction -- of having a diverse healthcare workforce. Therefore, it's not unreasonable to suggest that in order to correct the noticeable under-representation of racial and ethnic groups in the nursing workforce, there is a need for data to substantiate this reality.

The most recent (2005) Canadian Nurses Association (CNA) statistics on the nursing workforce show there are 268,376 registered nurses in Canada. Of these, 251,675 are practicing nurses (CNA, 2005, p. 1). The majority (35.5%) of Canadian Nurses Association statistics practicing registered nurses work in Ontario (CNA, 2005, p. 1). At this juncture, there is no readily available comprehensive source of racial and ethnic data on the Canadian Registered Nurse workforce; thus, any estimates of the precise number of racialized nurses in managerial positions are subject to debate. Achieving racial and ethnic minority representation in the nursing leadership workforce

is crucial to the growth of the profession, and for providing culturally competent patient care.

Over the last several years, however, in the absence of quantifiable numbers, a small but growing body of nursing literature has suggested that the number of racialized Canadian nurses in formal leadership and decision-making positions lags considerably behind the numbers in the RN population (Collins, 2004; Das Gupta, 2002; Turriffin et al, 2002; Villeneuve, 2002/2003). This despite many having advanced educational qualifications and experience (Schmieding, 2000).

Although attention has increasingly focused on diversity management in healthcare (Swanson, 2004), the number of racialized nurse managers in Metropolitan Toronto is dismally low considering its diverse population (which now accounts for about 11% of Canada's population). According to the 2001 Census, (as cited by the Canadian Association of Social Workers, 2005), African Canadians are the third largest visible minority group in Canada. In 2001 there were 662,000, representing nearly 2% of the population. Of this number, 346,145, or 52% of the total Black population, were Black women of African descent (p. 2).

A plausible explanation for the absence of race-based data on the nursing workforce in Ontario may in part be due to the OHRC prohibition preventing organizations from routinely collecting employee data on race and ethnicity (OHRC, 1997). Based on anecdotal reports, many nurses in Metropolitan Toronto are unaware that data related to the ethno-racial composition of the nursing workforce can be legally collected for monitoring and evaluation purposes.

Currently in workplaces in Ontario, employers can collect data on the race and ethnicity of their employees for the purpose of ameliorating racial discrimination and injustice, through special program provisions under the Human Rights Code, as set out in the Charter of Rights and Freedoms (Section 15.2). Section 14 of the Code allows the implementation of special programs that are:

- designed to relieve hardship or economic disadvantage; or
- designed to assist disadvantaged persons or groups to achieve opportunity; or
- likely to contribute to the elimination of the infringement of rights protected under the Code (OHRC, 1997).

It is my opinion that criticism can be directed at the professional nursing associations of Canada -- the Registered Nurses Association of Ontario [RNAO], the CNA, and the College of Nurses of Ontario [CNO] -- for not collecting data on the racial and ethnic composition of the Ontario nursing workforce. Through this study, I am making the case for the CNO to establish a special program to gather numbers whereby it can monitor the racial disparities in career advancement.

I maintain that this lack of data is a significant barrier to diversifying the profession of nursing at all levels. It is particularly worrisome that without accurate and current data to understand where and how these disparities occur, the under-representation of racialized nurses in management positions will remain both unchanged and unchallenged because no decisive conclusions are possible.

While I cannot categorically state the reasons behind this lack of commitment to gather accurate and current data, one plausible explanation for the absence of a system to monitor the racial and ethnic background of the Canadian nursing workforce is the failure

of nursing associations and healthcare organizations to acknowledge both racist practices in nursing and the devastating impact of these practices.

Unlike Canada, data related to the race and ethnicity of the population is routinely collected in the U.S. and the U.K. This data is used by the United States Department of Justice Human Rights and Equal Opportunity Commission, to investigate complaints of employment bias under the 1964 Civil Rights Act.

On the other hand, over the past several years in Canada, concerns from members of minority backgrounds, including racialized nurses, have been documented regarding the possibility of racial and ethnic information being used inappropriately to further discriminate against disadvantaged persons or groups. To date there is no evidence to prove that such data has been used in this way, although were it to happen, these concerns could in time be addressed.

Interestingly, registered nurses and registered practical nurses licensed in Ontario, Canada, are required every year, at the time of renewing their CNO registration, to report demographic characteristics such as their employment status, position, primary area of practice, gender identity, age group and their highest level of nursing education (CNO Membership Statistic Report, 2005; Sajan & Roy, 2006). However, as previously noted, race and ethnic information is not collected. Not surprisingly, Sajan & Roy (2006) posit, “Data collection...needs to keep pace with the [ethno-racial] evolution of the nursing profession...” (p. 35).

Although it is widely suggested in Canadian nursing literature that age and gender-related issues have significant implications for the discipline of nursing for those desiring change, the truth remains that matters related to race and ethnicity also have

significant implications for the profession of nursing and the healthcare system in general.

Despite the refusal of professional nursing associations and colleges to do the right things and support the collection of ethno-racial data on the nursing workforce, the RNAO (2002) policy statement on racism clearly indicates that healthcare organizations have a responsibility to ensure all nurses and healthcare clients are treated respectfully, and not subjected to racism and other discriminatory practices. At the same time, the RNAO statement acknowledges that "...nurses may encounter racism from multiple sources including clients and their families, colleagues (nursing and others), and systems and structures within the workplace," and declares that it is supportive of "...initiatives undertaken by agencies and organizations to eliminate discrimination and racism in any form, any workplace, and in the profession" (RNAO, 2002, p. 2). Similarly, the CNA position, as stated in Promoting Culturally Competent Care, acknowledges that healthcare organizations "...are responsible to create environments that promote a positive response to diversity" (CNA, 2004, p. 2).

On the basis of the above statements, the conclusion can be drawn that professional nursing organizations do not condone racism and other forms of intolerance in Canada's healthcare system. Yet it is of particular concern that, despite the platitudes, nurses from minority racialized groups continue to face myriad forms of racial discrimination in Canada's healthcare workplaces. The issues of racism and discrimination facing many Canadian Black nurses are not recent occurrences, but rather long-standing, albeit minimally documented, struggles in Canadian nursing history.

Institutional racism in Canada's healthcare delivery systems and the nursing profession is neither new, recent, nor a phenomenon unique to Canada. In the context of the U.S., similar findings of racism and discrimination against racialized nurses are acknowledged in nursing and healthcare literature (Barbee, 1993; Coffman et al, 2001; Diccico-Bloom, 2004; Dombeck, 2003; Glazer, 1991; Jackson, 1998; Keepnews, 2006; Lipsey, 1999; Malone, 1998; McPherson, 2006; Spratlen, 1998; Vaughan, 1997; Wilson, 2003), and in the U.K. Culley, 2001; Culley, Dyson, Ham-Ying and Young, 2001; Fernando, 1996; Hakesley-Brown & Malone, 2007; Lee, 1999; Sawley, 2001).

It should also be emphasized that, despite claims of inclusiveness and increased ethno-racial diversity in nursing in Western healthcare organizations, and notwithstanding the increased representation of racialized minorities in the profession, there is still cause for concern because minority nurses in Canada, the U.K., and the U.S. continue to struggle for professional recognition and equality comparable to their White counterparts. Research findings consistently report that institutional racism and racial discrimination continue to be deleterious to the work experiences of racialized nurses.

In the U.K., there is a plethora of research literature regarding racialized nurses and their experiences of racism in the National Health System (Lipsey, 1999). The small body of Canadian research data about racialized nurses also suggests that institutional racism in many of Canada's healthcare institutions poses significant challenges and barriers (Calliste, 1996; Collins, 2004; Das, Gupta, 1996, 2002; Hagey et al, 2001; Hardill, 1993; Hoff, 1994).

It is noteworthy that the research literature regarding racialized nurses in formal leadership roles is even sparser. I contend that although there have been numerous

studies: Maslove & Fooks (2004); Torgerson (2007); Baumann & O'Brien-Pallas (1993); Attridge & Callahan (1990) about the quality of work life of Canadian nurses focusing on issues related to workload, salaries, etc., there has been little attention given to issues related to race and racism as factors that negatively impact racialized nurses' quality of work life. What research there is suggests that the institutional racism in many of Canada's healthcare organizations plays a major role in the historical under-representation of racialized minority nurses in formal leadership roles (Villeneuve, 2002/2003).

As the nursing profession in Canada continues to be plagued with issues of race and racism, it is essential to define the characteristics that define the nature of this discrimination. Barbee (1993) asserts: "Three types of racism characterize nursing: denial, the color-blind perspective, and aversive racism (p. 350).

Denial emerges as complicit, both in regard to the victimized, and those who are actors in the victimization. Accordingly, Barbee (1993) suggests, "Black nurses may either hesitate to use the term racism or believe that the profession's work supersedes racism, but Euro-American nurses use a different form of denial: glossing discourse about difference under the rubric of cultural diversity" (p. 351).

Barbee (1993) continues, "As the issue of race is subsumed under cultural diversity, racism becomes reduced to ethnocentrism" (p. 351), adding, "Those who subscribe to the color-blind perspective believe that race has no relevance to an individual's behavior; race is an invisible characteristic" (p. 351). In other words, "Race becomes a taboo topic, and social life is a web of interpersonal rather than inter-group relations" (Barbee, 1993, p. 351).

Aversive racism, according to Barbee (1993) "...is characterized by ambivalence: feelings and beliefs associated with an egalitarian value system conflict with unacknowledged negative feelings and beliefs concerning Blacks" (p. 352).

In the context of nursing, the manner in which racism is dealt with is "...a reproduction of the profession's own tradition" (Barbee, 1993, p. 353). Thus are revealed the systemic complexities that dictate social and interpersonal constructs, perpetuate stereotypes and racial beliefs, and ultimately influence professional nursing hierarchies.

It has been argued that hierarchical stratification in nursing based on race and class creates both prejudices and privileges for nurses of different racial groups (Glazer, 1991; McPherson, 2006). Flynn (1999) and McPherson (2006) point out that the social constructions of 'professionalization' and 'proletarianization' create a differentiation in nursing that encourages racial and class differences, and change the makeup of the nursing workforce and the types of work nurses perform. Flynn (1999) further suggests that White women have assumed the responsibility and authority to define the boundaries of 'professionalization', and have adopted different standards for Black and White women.

Accordingly, Flynn (1999) argues that White nurses have benefited from 'professionalization', which typically reflects Anglo-Saxon values and beliefs. Flynn (1999) further argues that White nurses are generally considered to possess the knowledge and skills required to assume and function in managerial or supervisory positions. Brand (1999) notes that positive stereotypes support the belief they (Whites) are "more intelligent, more advanced and more competent" as compared to Blacks, who are negatively stereotyped as being less intelligent, backward and incompetent (p. 93).

Because of negative racial stereotypes, Black nurses are typically viewed as 'proletariats', which places them in a subordinate position to their White colleagues (Flynn, 1999). Thus, in the context of nursing, the notions of 'professionalization' and 'proletarianization' are relevant to the overwhelming representation of White nurses in managerial or supervisory positions, and the under-representation of Blacks in similar posts.

In the race and class hierarchical nursing structure, registered nurses generally occupy the apex, followed in order by registered practical nurses, non-professional caregivers such as nurses' assistants, and then aides and orderlies who are at the bottom level (Glazer, 1991). The social class status that is embedded within our society and educational institutions creates barriers and maintains discriminatory processes which hinder racialized women from gaining entry into university nursing programs to be trained as registered nurses. An individual's basic education level will determine the types of entry-level education programs that are accessible to those interested in a nursing career. Moreover, class status typically predetermines whether or not an individual or their family will be able to finance their education. The cost of university nursing education programs leading to a registered nursing degree may be prohibitive for many racialized students. Undertaking a four year registered nursing degree could be a barrier for individuals who may have to work to financially support themselves and family members, and may also not have the time to study. Students who are able to secure funding may choose to undertake the registered practical nursing program which generally is completed in a shorter timeframe and is less costly.

The literature suggests that within the professional nurse category, typically White nurses are much more likely to be registered nurses than racialized minorities, although the numbers of Black registered nurses show a steady but slow increase. There is further evidence suggesting that there are more Black registered practical nurses than Whites. As well, there is evidence that working-class women of colour, and Blacks in large numbers, are employed as non-professional nursing personnel (Glazer, 1991). Important to note that the nature of the work for non-professional caregivers involves 'heavy lifting' and other mundane tasks for which they are paid considerably lower wages and have limited job security (Das Gupta, 1996).

In the next section of the literature, I will focus on Canadian studies addressing issues of race and racism in nursing. As previously earlier, only a small number of Canadian studies have focused on Black nurses and their experiences in a culture of racism in many Canadian healthcare organizations and settings. McPherson & Stuart (1994) have observed the lack of scholarly research on Canadian nursing around issues related to race and ethnicity in the profession, and how a socially constructed identity of race and ethnicity shape "nursing work" (p. 11).

Head (1985) conducted one of the earlier studies in Toronto that focused on issues of race and racism in the healthcare workplace. This study described healthcare workers' attitudes and perceptions regarding specific aspects of their employment, and examined fairness in work assignments, performance evaluations, and success in achieving promotions, lack of decision-making opportunities, experiences of patient harassment, employment satisfaction and living in Canada. Head's research was commissioned by the Race Relations Division of the OHRC, and is considered a landmark by many

scholars because it focused on racism in various healthcare facilities in Toronto in the early 1980s, a time when racial issues in such institutions were considered taboo topics.

One of the strengths of Head's study was the large randomly selected sample of 79 Blacks, 38 Whites, and 14 other racial minorities, from 17 healthcare facilities. Over three-quarters of the sample worked either in teaching or general hospitals; almost one-fifth in special care hospitals; and the remainder in public health facilities, nursing homes, health centers, and rehabilitation centers. Of the sample, over half were registered nurses employed as staff nurses; four were head nurses; and two were assistant head nurses (Head, 1985).

Through the use of a ten-part questionnaire, Head collected data by telephone and face-to-face interviews. The findings revealed that most non-healthcare workers experienced varying degrees of workplace discrimination based on their race and colour. The research further indicated that racialized nurses concentrated at the lower levels of nursing generally perceived they had minimal opportunities for promotion into supervisory roles, in spite of having the appropriate educational credentials and work experience (Head, 1985).

These results are not dissimilar to those revealed by Hughes & Dodge (1997), who cite an American study by McGuire & Reskin (1993) which found that "African American women received fewer rewards for their credentials in terms of job authority and earnings potential than did African American men, White women, or White men" (p. 583). The starting point for analysis of Head's exploratory study is the fact that it was conducted in 1985, a time period when it was not 'the done thing' to allege racism in

healthcare organizations. During that same time frame, overt discrimination and racism were common practices within our society.

Admittedly, during this timeframe most organizations had not taken steps to enforce human rights and diversity policies and practices within their facilities. Therefore, it is reasonable to suggest that some of the findings of this study reflected the practices that typically went unchallenged in many organizations. One such finding was a “disproportionate number of visible minority staff nurses [were] reported to the College by their supervisors for “...breach of nursing standards” without proper and complete investigation of the cause for the complaint” (Head, 1985, p.9).

In more recent years, blatant acts of racism and discrimination are no longer socially acceptable. Therefore, this and other occurrences would be challenged by the nurses’ union, or the human rights department that is now in most healthcare organizations. Similarly, other incidents reported in Head’s study by visible minority nurses of “instant dismissal, decertification or suspension of [nursing] license, summoned to...disciplinary meeting[s] with personnel representatives following complaints from their supervisors” (Head, 1985, p. 11) are practices that would not be condoned in our present society in which employers are expected to adhere to anti-discriminatory and anti-racism policies and legislation.

Additionally, visible minority nurses in Head’s study reported being “assigned to less preferred geriatric duties as opposed to the desirable areas such as medical surgery, emergency, obstetrics and gynecology” (Head, 1985, p. 15). Given the present severe shortage of nurses that has created the challenge for healthcare organizations of filling large numbers of nursing vacancies, this is a finding less likely to be reported in more

recent studies. It is important to note that the current practice in healthcare organizations is to hire nurses for their preferred area of clinical practice, and based on vacancy availability.

Interestingly, Head's study reported, "Nurses of visible racial backgrounds are not represented at the decision-making and supervisor levels. They are, however, well represented at the lower levels" (Head, 1985, p. 9). The findings of more recent studies, including the present study, suggest that while racialized minority nurses may now be represented in leadership and decision-making positions, nonetheless they are disproportionately underrepresented.

It is noteworthy that Head's study and the more recent studies all consistently suggest that race plays a significant role in shaping the experiences of racialized minorities in the healthcare workplace. For the record, the participants in Head's study worked in various types of healthcare jobs, although the vast majority of the sample was nurses. An additional divergence from the present research is that the participants in Head's study were from various ethno-racial backgrounds. These factors may have contributed to the outcome of the research, and therefore the characteristics of the heterogeneous sample make it difficult to generalize the research findings. Additionally, the conclusions drawn are weakened by the research design. Conversely, the present research study uses a less heterogeneous sample of subjects, which makes the findings more amenable to generalization.

A study by Calliste (1996) focused on racial minority women, specifically African Canadian nurses engaged in "resisting racism in nursing in Ontario and Quebec from the late 1970s to the 1990s" (p. 362). Calliste used an integrative antiracism theoretical

framework to “examine the conditions under which antiracist struggles materialized, the constraints placed upon these nurses, and the effects of their struggles” (p. 362).

Participants for the study were recruited from Ontario and Quebec because of the large cohort of Black nurses in these provinces. Data was collected from 1994 to 1995 from a snowball sample of 22 registered Nurses, three nurses’ union officers and five community organization members, through 30 semi-structured interviews. The primary research data was augmented by analysis of OHRC records, labour arbitration cases, community organizations and other secondary sources.

Calliste’s data analysis revealed widespread workplace discrimination against Black nurses, who reported they were treated differently than Whites. They were verbally abused by patients and colleagues, marginalized, silenced and excluded by staff members. Black nurses in the study also reported being negatively stereotyped as less competent and requiring more discipline, thus justifying disciplinary proceedings. Furthermore, and of specific salience to this dissertation, the research found that racial minority nurses were rarely in leadership positions, even in facilities with large numbers of visible minority staff.

In Calliste’s study the data source was not primarily nurses and, as well, various secondary sources were used. It is important to note, however, that some of the findings of Calliste’s study are congruent with those of the present research. In essence, Calliste’s research reveals that racial dynamics persist in Canadian nursing.

Notably, the study by Hagey et al (2001) examined the experiences of immigrant nurses of colour who filed grievances against their employers for discriminatory practices they experienced in the workplace. This particular study sample consisted of nine

registered nurses who immigrated to Canada from seven different countries between 1960 and 1980. The cohort had worked in staff nurse and managerial positions from seven to thirty-three years, in various healthcare facilities.

Qualitative data were collected from the participants through semi-structured interviews and focus groups. Hagey et al (2001) used discourse theory to analyze and interpret the participants' responses. Their findings exposed significant impediments to the respondents' career upward mobility due to discriminatory workplace practices. Furthermore, many of the participants in the study reported serious health consequences attributed to the stress of filing a grievance or complaint related to their experiences.

Although this study confirmed the reality of racism in Canadian nursing, the participants were selected on the basis that they had experienced some form of racism in the workplace. Additionally, the participants in the study were asked to describe their experiences of racism and discriminatory practices within the workplace. Unlike the present study, the women in Hagey et al (2001) study had all charged their employers with racial discrimination.

Another research worth pointing out is Das Gupta's (2002) exploratory study that investigated systemic racism in the nursing profession in Ontario. The research focused on the participants' experiences with everyday racism, the perpetrators of racism, health issues caused by racial harassment, and actions taken following harassment.

The multi-ethnic sample was comprised of 311 Europeans (52.4%), 62 Black/Africans (10.5%), 122 identified as 'other' (20.6%), 60 Asians (10.1%), 18 South Asians (3.0%), 1 Aboriginal/First Nations (.2%), 7 Central/South Americans (1.2%), and

12 unknown identities (2.1%). Of the 122 identified as 'other', most of these were mixed raced women (Das Gupta, 2002, p.8).

Qualitative research data was collected through telephone and in-person interviews with 13 respondents, surveying 593 Ontario Nurses Association (ONA) nurses, a review of 19 ONA nurses' grievances, and a review of secondary literature on racism in nursing (Das Gupta, 2002, p.8). The study findings are consistent with past studies on racism in nursing and healthcare institutions, and support the contention that racial minority nurses experience racism in the healthcare workplace. An important finding of the study is that White nurses reported very little discrimination in contrast to the very high rates reported by the Black nurses.

The large sample size could be considered one of the strengths of Das Gupta's study. However, unlike the present study, the participants are unionized staff nurses. Other points of divergence from the present study are the multiple sources of data collection used, and the comparative data that was collected from White nurses. Additionally, the cohort was comprised of a multi-racial sample including Blacks, Asians, Aboriginals/First Nations, Whites, and South Americans. Nevertheless, a convergence point for this study and the present research is that the findings of both suggest that racism in nursing and in many healthcare organizations negatively affects the work lives of racialized nurses.

Collins (2004) qualitative research examined how race, gender and class affected the experiences of 14 female registered nurses of African descent in the workplace, specifically in the area of career mobility. The research participants immigrated to Canada from seven Caribbean countries, and worked for a minimum of 10 years in

various nursing positions. Data for the study was collected through in-depth and semi-structured interviews, and analyzed using critical race theories. Collins' findings revealed that the participants experienced significant workplace barriers in their careers due to systemic discriminatory practices.

One of the salient findings of earlier studies is that race-based discriminatory practices generally hinder racialized nurses from accessing decision-making positions. Because of the gap in the current literature on racialized female nurse leaders, the present study builds on the aforementioned research to focus specifically on how race affects the work lives of Canadian Black female nurses in leadership roles.

Research Objectives

This research study explores the experiences of 16 African Canadian female nurse leaders and, in particular, their perception of the influence of race on their work experiences. The research focuses primarily on Black women because other research shows that their experiences are usually different from those of other women.

The overarching goal of the study is to redress the gap in the current nursing literature on African Canadian nurses in leadership positions. The specific objectives are to:

- 1) Provide an opportunity for self-identified Black women in formal nursing leadership positions to share their experiences in the healthcare workplace, and to highlight the challenges they have faced at the managerial level;

- 2) Reach a more informed understanding by examining how the social constructions of race shape the experiences of African Canadian/Caribbean female nurses in healthcare management in Metropolitan Toronto;
- 3) Describe how minority women understand their own oppression and what resistance and coping strategies, if any, they employ in their respective workplaces.

Summary

This chapter provided a general overview of the relevant literature and the empirical research that informed the present research study and the choice of methodology for the study.

The first section dealt with the historical context of immigration and multiculturalism, the immigrant experience, and diversity in the general labour market and in healthcare workplaces. Next, I provided a brief overview of racial discrimination and prejudice in the labour market and the status of Black women in the labour market and the healthcare workplace, followed by a brief historical overview of the experiences of Blacks in Canadian nursing, and a critical analysis of more recent empirical research on racialized Canadian nurses.

The literature presented in this chapter has been helpful in providing insight into some of the complex issues related to race and racism that affect racialized people in Western society, and particularly African Canadian nurses' quality of work life. The results of the aforementioned studies appear to reach the same conclusion: that institutional racism and discriminatory practices and attitudes are often imbedded within

healthcare workplaces, and may serve to exclude and marginalize, and deny opportunities and rights, to individuals who should be protected under the Human Rights Code.

As a group, these studies reach the same conclusion: that racism and racial discrimination within many Canadian healthcare organizations negatively affect Black nurses work experiences. As an example, the data from these studies suggest that the career mobility of racialized minority female nurses is impeded because of ideologies of racism that reinforce negative beliefs about Black women being unsuitable for decision-making positions.

Most of these previous studies, however, ignore one major issue: the obstacles and discrimination encountered by Black nurses who have achieved positions of leadership. None of the studies included in the review examined in detail the work experiences of Black nurses who had achieved positions in leadership. One question motivating this study, therefore, was how Black female nurse leaders function in their roles in a predominantly White management workforce.

The present study builds on the work of the authors cited earlier to identify and address issues and concerns related to race and racism in the nursing management workforce. The current study's point of departure from the studies previously mentioned is its focus on African Canadian women in formal nursing leadership positions. Although earlier research findings suggest racism in the nursing profession hinders Black nurses' career advancement, these studies have not examined the experiences of those who have advanced up the career ladder against all odds.

As I stated at the outset of this thesis, to address this gap in the available research literature, the present study aims to explore and understand the experiences of Black

female nurse leaders in the workplace. In particular, this work aims to focus on how race influences and shapes the study participants' day-to-day work experiences. Further, the results of this study will add to the body of nursing scholarship about racialized minority nurse leaders, enabling a better understanding of their work experiences.

This literature review underscores the fact that there is a small but growing body of research knowledge on the impact of racism on racialized nurse leaders in Canada. Hence the reviewed literature has served to guide the formulation of the research objectives and specific research questions for this research study.

The next chapter presents the theoretical framework that underpins the current study, including the key theoretical perspectives of Black feminism and integrative antiracism theory.

CHAPTER THREE

THE THEORETICAL FRAMEWORK

Introduction

This chapter presents the theoretical framework of this study that consists of black feminist theory and integrative antiracism theory. Beginning with a brief overview of some of the key components of feminism, the chapter then summarizes the different philosophical approaches, specifically focusing on black feminist theory. This is followed by a discussion on integrative antiracism.

In reviewing the theoretical concepts, I further address the relevance of these critical discourses in analyzing the role race plays in the participants' experiences in their respective workplaces. Also identified are the points of convergence and divergence between the two critical discourses.

These discourses provide the critical lens to explore and critique the inequalities and discrimination linked to categories of difference, as well as exposing the complex genesis of inequitable practices that are a daily reality for African Canadian women in nursing leadership positions.

While there is a degree of compatibility between the two theoretical approaches underpinning the current research, it is very important to understand the strengths and limitations of these perspectives, as well as their points of divergence and convergence, and their relevance to the current project.

The Politics of Race

To understand the complexities of racism and racial discrimination in the everyday experiences of many racialized people in Western societies is to first understand the concepts of race and racial stratification. First and foremost it should be noted that there is no empirical evidence supporting a biological or genetic basis for the race concept (Bashi & McDaniel, 1997). Dei (2000), among others points out that race is a category of human identify which is socially constructed.

According to Haney Lopez (1995), "...race is neither an essence nor an illusion, but rather an ongoing, contradictory, self-reinforcing, plastic process subject to the macro forces of social and political struggle and micro effects of daily decision" (p. 193). The significance of race in shaping intergroup dynamics cannot be understated, and it is important to note that the social construction of race reflects the interests of the dominant White group.

It is almost impossible to understand race and racism without placing them within a historical, social and political context (Britton, 1999). The aftermath of slavery and colonialism continues to have a devastating impact on racialized people, particularly Blacks in various ways (Bashi & McDaniel, 1997; Spratlen, 1998). Beginning with slavery, ideological forms of racism stigmatized Blacks as subhuman, and as such, they were treated inhumanely.

The institution of slavery in the U.S. is well documented. However in Canada, the documentation has been predominantly focused on this nation's role as a provider of safe haven for African Americans escaping from slavery. In most of the discussions related to the enslavement of African people in North America, there seems to be a

downplaying of the Canadian legacy of slavery, colonialism and imperialism. In fact, this legacy continues to shape the life experiences of Canadians of African descent.

One of the main legacies is the deep-rooted racism entrenched in contemporary structures in Western societies. With this in mind, social injustices in White dominant societies perpetuate the exploitation and subjugation of racialized people, particularly Blacks, through to the twenty-first century (Spratlen, 1998).

Saloojee (2003) points out that “racism creates a dual labour market that leads to the super-exploitation of workers of colour” (p.3). Saloojee further suggests that “because...of discrimination and barriers...people of Canadian society do not start from the same spot, and do not compete on an equal footing with each other” (p. 4). Spratlen (1998) says that the combination of “prejudice and power fuel(s) practices of superiority in the dominant group, and imposes patterns of inferiority upon the oppressed group” (p. 6). Another comment Saloojee (2003) makes is that, “Racial inequality and discrimination are both product and combination of power imbalances in society: as well, they are a function of structural constraints that are rooted in the fabric of society” (p.4).

Those in positions of power (the White dominant group) invoke a doctrine of superiority to ensure domination over those who are perceived as different and inferior (Feras & Elliott, 1992). Clearly, within this context, Blacks and Whites are positioned unequally with respect to the notion of power. In the context of this study, the aftermath of a long history of slavery continues to shape the day-to-day experiences of people of African descent, including nurse leaders of African descent employed in many of Canada’s healthcare institutions. “Racially-gendered hierarchies” that are deeply

embedded in the social fabric of Canada, and entrenched in many social institutions, have served to perpetuate the ideology of Black women's inferiority (Brand, 1999, p. 84).

Although a number of scholars posit the view that race, gender and class cannot be understood or critique independent of each other, nonetheless, race was the primary focus for analysis in this research. As mentioned elsewhere, this study seeks to draw attention to the unique experiences of Black nurse leaders, and to demonstrate how the notion of race defines these experiences.

Racial Stratification

Hagerstrom (2003) writes that "...processes of racialization...mean that people and cultures, are defined as different, as others, subordinate, and also hierarchised in terms of assigned racial characteristics, especially colour of the skin or other signifiers that make us different" (p. 8). Scholars such as Dei (2000) and Bashi & McDaniel (1997) posit that racial stratification affects individuals and groups with different implications for status or moral worth. The ideology of racism is based on a racial hierarchy which supports the ideology of white dominance and privilege, and also imposes inferiority and subjugation onto people of racial minority backgrounds (Isajiw, 1999).

Regarding the social construction of whiteness, it assumes a privileged social position from which all other racial identities come to be defined differently (Dei, 2000). Dei (2000) further posits that whiteness is recognized as a powerful racialized identity that benefits from all aspects of society regardless of gender, class, or sexuality. In a more critical fashion, whiteness, as the recognized voice of preeminence has the ability to decide whose voice and opinions are listened to, shut up, or ignored (Dei, 2000). As the

inevitable marker of privilege and power, whiteness assumes a superior justification to dominate, exclude and discriminate against racialized minority groups that are socially constructed as inherently inferior and lacking self-worth.

Racialized Discrimination

In this section the argument constructed is that racism as a form of social exclusion has a devastating impact on those whose lives it affects. There is no doubt that the history of Black people in Western societies is one of relentless struggles against anti-Black racism and discrimination. Das Gupta (1996) argues that racism involves a process of racialization where individuals are viewed and socially defined as being members of a discrete race. The result of racialized processes is that many racialized minorities continue to be relegated to the periphery of society, and subjected to structural, institutional and systemic racism and racial discrimination (Britton, 1999).

Saloojee (2003) maintains that “racial inequality and discrimination are...products and confirmation of power imbalances in society” (p. 4). Intended or not, power structures are mediated by race, class, and gender, to name a few. Those aligned with positions and relations of power are able to invoke the notion of White superiority to ensure authority over Blacks and other racialized minorities who are considered different and inferior to the White dominant group (Feras & Elliott, 1992). Within this context, racialized minorities and White Anglo-Saxons are positioned unequally in the social and institutional power structures. Expressions of racism can be conveyed in various ways, can be deliberate or inadvertent, cultural or ideological, individual or systemic. In recent years, racism and racial discrimination are rarely exhibited overtly because of the social

stigma associated with the practice; hence, race-based discriminatory practices have gotten more subtle and covert.

Feminism and Feminist Theorizing

Pati's (2006) definition of feminism is: "An awareness of women's oppression and exploitation in society, at work and within the family, and conscious action by men and women to change this situation" (p. 14). In essence, feminism is about challenging gender inequality in social structures. According to Pati (2006), "Feminism derives its origin from multiple theoretical formulations, and is based on historically and culturally concrete realities and levels of consciousness, perception and action" (p.13).

Theoretically, the different perspectives include: black feminism, radical feminism, liberal feminism and socialist feminism (Haslanger & Tuana, 2006). The literature suggests that each perspective involves different assumptions about the root causes of women's inequality and oppression (Pati, 2006). For example, liberal feminism locates women's oppression in their lack of equal civil rights and educational opportunities (Freeman, 1990). On the other hand, socialist feminism teaches that women are oppressed, exploited and discriminated against not because of biological differences, but because of their subordinate class status within a capitalist society (Ferguson, 1999). Socialist feminism views the oppression of women in the context of class structure. Moreover, as is often pointed out, socialist feminists believe that social class, through the workings of capitalism, influences the opportunities available to women, and is a significant factor in determining the relationship between women and men. Most notably, "...although radical feminism engaged with questions of difference, its

privileging of gender as the difference, and focus on differences between women and men (as opposed to differences among women themselves), erased the agency and diversity of women” (Weedon, Chris. *Feminism, Theory*, n.d. ¶. 10).

As is evident from the aforementioned perspectives, “...it is rather difficult to establish what the theoretical and methodological ‘boundaries’ of the various approaches are, where they diverge and overlap and what approach or combination of approaches might prove more productive (both empirically and politically) for feminism” (Speer, 2005, p. 8). Speer posits:

It’s easy to get bogged down in the detail of the different [perspectives] that are reported, at the expense of gaining a broader understanding of how diverse theoretical and methodological models that are represented relate to each other, and a sense of their possibilities and problems (p. 8).

Thinking in a similar vein, Pati (1991) writes:

Although [the various approaches of feminism] converge on the core issue of women’s subordination, they differ in their assumptions about the causes or sources of that subordination. These differences reflect the richness of women’s lives and the need to integrate the experiences and knowledge of women across the globe, and a move towards a more inclusive, sensitive theorizing about both women’s subordination and their power (p. 15)

It has also been suggested, however, that the various feminist perspectives are at times in conflict with each other. Arguably, the premise of this view may be attributed in part to the divergence of theoretical dimensions on the main source of gender inequality in society. Arguably as well, scholars such as (Calliste & Dei, 2000; Robinson, 1999; Riley, 2004; Mirchandani, 2003) make the point that individuals have multiple identities that are interrelated. Included are race, gender, class, sexual orientation, etc.

Along these lines, Mack-Canty (2004) notes, “These feminisms, rather than working from established and usually abstract foundational theories, [should] begin from the situated perspectives of different women” (p. 154). Most importantly, although each feminist perspective has its own limitations, they all aim to broaden our understanding of women’s lives, describe and analyze gender-based inequality, and provide strategies to achieve women’s liberation (Lorber, 2007).

It is acknowledged that mainstream feminisms originate from a White middle-class belief system. A major critique of mainstream feminisms is the exclusion of the everyday realities of marginalized women, including indigenous and racialized women or other women with low socioeconomic status, from their political focus and agenda. Furthermore, it has been mentioned that the primary attention of mainstream White feminists was to address patriarchal oppression and strive for “...the limited emancipation of well-to-do White women... and recognition by society” (Scott, n.d. ¶. 4).

Therefore it is not surprising that a criticism against the mainstream feminist movement is its failure to recognize women of colour and White women of lower economic classes. In part, to achieve equality for all women, other dimensions such as racial identity, class, sexuality and physical ability have to be integrated into the gender perspective. Because mainstream feminisms generally do not acknowledge the multiplicity of identities and their intersectionality, it is reasonable to suggest the role of these perspectives in facilitating an analysis of Black women’s experiences would be limited. Considering this, anti-racist feminism is crucial as a strategy because it delineates and ethically challenges social constructions of identity. The identities of concern are those based on a Eurocentric/andocentric hegemony that marginalize Black

people in general and, of relevance to this study, Black female nurse managers specifically. Anti-racist feminism is essential if these women (and others) are to move from the margin to the centre.

In rethinking anti-racism, critical scholarship must consider how to begin to attend ethically to the social construction of relations which constitute racial minorities and women's possibilities for participating both within and beyond the ideologies serving a system of national and global economic/political interests aligned as they are with hetero-patriarchal Western/Northern elite (Calliste & Dei, 2000, p. 13).

Mainstream Feminism vs. Black Feminism

Essentially, as noted earlier, the roots of contemporary feminisms originated from, and progressed within, the experiences of middle-class White women (Brand, 1999; Carty, 1999; Collins, 1990, 2000; Cole & Stewart, 1996; Hamer & Neville, 1998; hooks, 2001; Maynard, 2001). Indeed, Hamer & Neville (1998) contend that contemporary feminisms "...are all traditionally white bourgeois perspectives..." (p. 22). The literature suggests that contemporary feminisms remain wholeheartedly focused on issues primarily of interest to middle-class women. Brand (1999) asserts that it is a common practice of White middle-class women to articulate their oppression as being caused primarily by their unequal social positioning with White middle-class men.

Some scholars argue that White feminists have focused attention on issues of gender oppression while ignoring other forms of oppression caused by ideologies of race, class and sexuality (Anderson, 2000; Amos & Parmar, 2001; Cole & Stewart, 1996; Cuadraz & Uttal, 1999; and Darlington & Mulvaney, 2002). hooks (2001) submits that White feminists invariably direct their discourse to a "...White audience and focus solely on changing attitudes rather than addressing racism in a historical and political context"

(p. 37). And hooks (2001) also writes that White middle-class women, "...rarely question whether or not their perspective on women's reality is true to the lived experiences of women as a collective group" (p. 34).

Typically, White middle-class feminists have not taken seriously the issues confronting Black women, other women of colour or women of lower economic status (Agnew, 1996; Amos & Parmar, 2001; Baca-Zinn & Thorton-Dill, 1996; Collins, 2000; Taylor, 1998). hooks (2001) states furthermore that racism proliferated in much of the earlier writings of White feminists, thereby strengthening White domination. She argues that White women frequently advance, "...a false image of themselves as powerless, passive victims...to deflect attention...from their aggressiveness [and] their willingness to dominate and control others" (p. 38).

Despite White feminists' denial of these claims, Brand (1999) has pointed out that "...feminist themes have lent themselves to capitalist, racist and imperialist ideologies" (p. 84). hooks (2000) suggests that, "Privileged feminists have largely been unable to speak to, with, and for diverse groups of women because they either do not understand fully the interrelatedness of sex, race, and class oppression or refuse to take this inter-relatedness seriously" (p. 15).

White feminists frequently embrace the notion that women have similar experiences of gender oppression. This implies that that all women share common experiences and face the same issues regardless of social categories such as race, class and sexuality. For the most part, this line of argument is based on the notion of a universal sisterhood among women. However, this notion is generally opposed by Black feminists who postulate that women's lives are influenced differently by their social

location based on race, class and sexuality, among other aspects of identity (Amos & Parmar, 2001; Bell & Nkomo, 2001; Welch, 2001).

Amos & Parmar (2001) also believe that "...mainstream feminist theory does not speak to the experiences of Black women and, where it attempts to do so; it is often from a racist perspective and reasoning" (p. 17). They further note that, "...contemporary feminist theory does not begin to adequately account for the experiences of Black women" (p. 18). Black feminist scholars (Carty, 1999; Collins, 2000; hooks, 2001) argue that contemporary feminist theories are inadequate for analyzing Black women's experiences, and generally do little to explain these women's oppression and marginalization. Escudero (2000) emphasizes, "...gender alone does not fully explain Black women's experiences of otherness and objectification" (¶. 4).

In fact, White middle-class feminists' assertions, that women's oppression is caused primarily by gender inequalities, fail to engage the fact that power relations and privilege are intertwined with issues of race and class. Agnew (1996) asserts that although, "White, middle-class women may be oppressed by their gender...they exercise greater power and privilege when compared to women from Asia, Africa, and the Caribbean" (p. 79). hooks (1984) notes, "Sexism as a system of domination...has never determined in an absolute way the fate of all women in this society" (p. 5), and argues that it is easier for women not experiencing oppression based on race or class identity to focus on oppression related to the patriarchal gender system. But, as Amott & Matthaei (1996) point out, gender issues cannot be understood independently from race and class.

It must be emphasized that in recent years various contemporary feminisms have, in varying degrees, begun to acknowledge that women's experiences are different due to

the implicated factors of race, class, age and sexuality. Still, it is reasonable to conclude that many of these perspectives have done little to advance the interests of ethno-racial minorities and women of low socio-economic status. As Brand (1999) states, “A feminist theory must root out the borrowed, unchallenged categories which have informed a mode of discourse used to repress the identity and claims of Black women” (p. 84). Agnew (1996) expressed a similar view that there is need for the different feminist perspectives to acknowledge diversity and differences among women, “...and that feminist theory must include more of the experiences of women of different races and classes” (p. 50). It is widely acknowledged that Black feminism challenges dominant feminist perspectives that alienate Black women, as well as racist hegemonic structures and practices that are designed to marginalize and exclude Black women’s viewpoints and experiences.

Black Feminist Theory

Black feminism originated in the U.S. in order to counter the exclusion of African-American women from mainstream feminism, i.e. white contemporary feminism, and to enable Black women to theorize their own experiences (Taylor, 1998). It evolved from the experiences of African American women, informed by their struggles against multiple forms of oppression (Collins, 2000). According to Collins (1990), “Black feminist thought encompasses theoretical interpretations of Black women’s reality by those who live it” (p.22), and provides a medium through which Black women’s voices are given centre stage (Reynolds, 2002).

Over the past decades Black feminists and feminists of colour around the world have formulated other black feminist perspectives to account for differences in Black women's experiences "...under different social, economic and political systems..." (Barnes, 2006, ¶. 8). For instance, Wane, as cited in Wane et al, 2002, p. 38) describes a Canadian perspective of black feminism as:

... [A] theoretical tool meant to elucidate and analyze the historical, social, cultural and economic relationships of women of African descent as the basis for development of liberatory praxis. It is a paradigm that is grounded in the historical as well as the contemporary experiences of Black women as mothers, activists, academics and community leaders. It is both an oral and written epistemology that theorizes our experiences as mothers, activists, academics and community leaders. It can be applied to situate Black women's past and present experiences that are grounded in their multiple oppressions.

Similarly, Mizra (1997) defined black feminism from a British perspective as "...a body of scholarship...located in that space of Britishness, that challenged hegemonic patriarchal discourses of colonial and now postcolonial times...which quietly embraces our common-sense and academic ways of thinking" (p. 3).

Based on the above definitions of black feminism, it is clear that Black feminist perspectives, regardless of the country of origin, converge on the opinion that Black women as a group share a unique standpoint because of their history of slavery and experiences of racism, sexism and classism (Hamer & Neville 1998). A review of the literature suggests that black feminist theory includes a comprehensive, antiracist and anti-sexist perspective of social change (Collins, 1990). Black feminism situates Black women's issues, concerns and perspectives at the center of analysis, and also provides insight into the dominant perspectives that undermine their womanhood (Collins, 1990).

Maynard (2001) suggests that "...focusing on Black women's experiences highlights the ways in which 'race' plays an important part in their social and economic

positioning” (p. 125). Undoubtedly race plays a key role (in shaping the day-to-day experiences of Black women in white contemporary society (Wane, 2002). Furthermore, racist ideologies create and maintain negative stereotypes and images of Black women, and have resulted in them having lower status in society than women of other racial groups (hooks, 2000).

According to Das Gupta (1996), Black women have struggled relentlessly to subvert the ideological construction of them being servant types, more suitable for work that is mentally less complex. Collins (1990) posits that all Black women share the common experience of living in a society that devalues them, and it is through those experiences that Black women develop a black feminist consciousness.

Collins (1990) indicates that black feminist thought exposes Black women’s oppression and enhances our understanding of its root cause. Dei (2000) expresses the viewpoint that the black feminist perspective allows for the experiences of women, who have been marginalized and silenced, to be heard and to claim discursive space, as in the case of the current research. In addition, black feminism provides a road map for a critique and interrogation of existing discourses that assign Black women an inferior status to White women.

When one acknowledges that contemporary feminist theories originate from a White middle class value system, it thus becomes particularly important for me as a Black woman, whose research is exclusively focused on Black women, to draw on a body of knowledge that reflects the perspectives of Black women. A black feminist discourse is essential in analyzing the issues encountered by the Black female participants which they perceived are related to their racial background.

Utilizing black feminist discourse in the current research also enables me to critically examine the power differential that exists between Black women and White women, as well as shedding light on the multidimensional dynamics of oppression experienced by Black women in their everyday lives. Its use in the current study is appropriate because it "...confronts race, class and sex as these converge in the dominant ideology" (Brand, 1999, p. 84), significantly shaping the work experiences of the research participants.

Taylor (1998) suggests that black feminism "...recognizes how systems of power are configured around maintaining socially constructed categories of race and gender" (p. 2). Dei, Karumanchery and Karumanchery-Luik (2004) argue, "Realizing that orthodox theorists never firmly established a connection between ideology, the material world, power and social change, we think there is a connective circuit that must be interrogated" (p. 61). I am in agreement with both. I maintain that the systems of power built on discriminatory categories of race and gender must be interrogated and dismantled. On the basis of the aforementioned, I conclude that black feminist theory provide "a set of powerful analytical tools" (Kirkham & Anderson, 2002, p. 1) suitable for an in-depth exploration, analysis and understanding of the experience of Black women nurse leaders.

Negative Stereotypes and Images of Black Women Based on Race

It could be argued that negative stereotypes about Blacks have become thoroughly ingrained in the dominant society consciousness. Hence an anti-racist stance must be employed if the many psychosocial depictions are to be ruptured. Interwoven with race, class, economic status, gender and sexuality, these depictions have been effectively

promoted through visual images and connotations that emerged in nineteenth century mainstream art and newspapers, and early twentieth century film and television. The impact of the visual cannot be underestimated. McElroy (1990) posits that

Naming is a form of power, and visible images have the persuasive power to identify and define place and personality. Whether through portraiture, genre scenes, allegorical history painting, or narrative realism, the work of artists of differing races and ethnic groups has detailed the prevailing negative as well as the rarer positive opinions that one race held for another (p. xi).

Thus negative stereotypes not only reside in the verbal expressions used to decry or denigrate Black women, but also in the visual images. These images, together with verbalization, interact to both create and then disseminate derogatory portraits of Black women that victimize and marginalize. Moreover, visual images are symbols that imprint(ed) on the mind an immediate and enduring social commentary designed to inflict pain, incite ridicule, and engender denial and dismissal of the Black 'object' or 'other' as sub-human.

McElroy (1990) emphasizes:

Prosperous collectors created a demand for depictions that fulfilled their own ideas of blacks as grotesque buffoons, servile menials, comic entertainers or threatening sub-humans. This vicious cycle of supply and demand sustained images that denied the inherent humanity of black people by reinforcing their limited role in American society. More fundamentally, these images expressed an inability to comprehend a people whose appearance and behavior were judged to be different from their own and thus inferior (p. xi).

Woven into a racially derogatory fabric, these images were according to McElroy (1990) "...shaped in no small part in terms of social class and economic status. Similar attitudes of class and economics would, in turn, inform many of the subsequent [White] artistic expressions of African-Americans in eighteenth and early nineteenth century America" (p. xi). The White-controlled media, through print, television and film, has

been active in perpetuating these false images about Black women, with stereotypes that all too often wallow in attributive labels purporting to describe Black women's sexuality, a circumstance that arguably reveals the White male's obsession with the sexuality of Black women.

It can thus be presumed that this obsession with sexuality emerged out of natural science and postulations of Darwinism, and sexuality became "a dense transfer point" of power. It was through 'bio-power' that bourgeois sexuality was "...shaped on the imperial landscape where the politics of language and race were utilized" (Stoler, as cited by Bedard, 2000, p. 46).

In Western dichotomous thinking Whiteness needed an opposite against which to define itself; thus other bodies were racialized and defined as contrary to the White bourgeois vision. Non-bodies, defined as highly sexualized and degenerate, were foils for White bourgeois sexual virtue. Bio-power was used to identify and control the degenerate not only outside the European state, but within it as well. Bio-power secured a relationship among racism, sexuality and class that defined the White bourgeois as racially pure and sexual virtuous (Stoler, as cited by Bedard, 2000. p.46)

From the slave plantations to eighteenth and nineteenth century art, cartoons and illustrations, to movies of the early and mid-twentieth century, and onward to this day, the Black woman has been and is all too frequently portrayed as something other than a good mother, wife, and citizen who is intelligent and capable. The film industry, which has tremendous sociological impact, has been a leader in perpetuating horrid stereotypes and negative images, many of which implicate Black women's sexuality. For example, Woll & Miller (1987) have argued that:

Discussions of [Black] female sexuality...gained fresh interest in the 1960s and 1970s. [T]he perpetuation of the mammy stereotypes to the creation of the over-sexed temptresses...[are] stereotypes, which in various forms date back to the silent era [and] include the tragic mulatto, the mammy or earth mother, the innocent, and the siren or seductress...Particularly frustrating to critics has been

the intractability of the female stereotypes which they largely attribute to the white- and male-dominated nature of the film industry, and which have burdened other minority women as well (pp.102-103).

Today, the legacy of these visual and printed images is witnessed in the generations that have derogatory imprints about Black women imbedded in their psyches, along with stereotypes of Black people in general as lazy, dirty, shiftless, criminal, undependable and incapable. Mainstream society has been all too willing to accept these stereotypes as true assessments of an entire people, and this acceptance enables easy justification for the inequitable treatment of Black women in the workplace today. The association of these images with contemporary perceptions of Black women cannot be viewed as isolated circumstance. As well, the fact that there are other images and stereotypes cannot be denied, whether it is that of today's Black 'superwoman' or the 'angry feminist'. Above all, none of the foregoing can be ignored as they all interlock to impact on workplace environments and the perception and treatment of Black women.

Essed (1991) note that the everyday processes of racism in the lives of Black women operates through concepts of marginalization, problematization and containment. Essed goes on to say that marginalization "...is a process in which a sense of "otherness" is perpetuated" (p. 112). For Black women, marginalization is often experienced through "various related subprocesses, including colour differentiation...,nonrecognition..., nonacceptance..., undervaluation..., and the obstruction of mobility" (p. 112). In other words, the reality of marginalization serves to subordinate Black women. For Essed (1991), the problematization of Blacks is a form of racism that may be experienced in complex ways such as "cultural denigration" (p. 114). Essed further note that "...problematization of Blacks reflects the way... ideological notions rationalize the

marginalization of Black traditions and values as well as the **exclusion...from access to material** and nonmaterial recourse...in order to contain them in relations of dominance” (p. 114). Essed (1991) further suggested that the concept of containment is also a form of everyday racism experienced by Black women for centuries. As an example, Black women may be denied the opportunity to talk about their experiences of racism. In this context, members of the dominant group may deny the existence of racism.

One of the core themes of black feminist thought is challenging the repugnant depictions of Black women that have developed from racist ideologies and used to justify their subordination (Collins, 2000; Escudero, 2000). Case in point, black feminist theory is beneficial to the current study for analysis of the Black women positioning as subordinates, albeit in positions of leadership. Conversely, racist ideology supports the belief among many dominant employers that Whites are more suitable than Blacks for leadership positions. However, in confronting the historical and contemporary background of vicious characterizations and practices, Das Gupta (1996) posits that negative stereotypes and representations of Black people render it necessary for anti-Black racism to be sustained by White society. As Collins (1990) and hooks (2001) argue, one unique aspect of Black women’s oppression comes in the form of degrading stereotypes and demeaning constructions forced upon Black womanhood. As a result, Black women have never held high social status in predominantly White societies, and the social status of Black women is “...lower than any other group” (hooks, 2001, p. 38). Based on this line of argument, the ideology of a racist system is to maintain structures created to keep Black women in states of dependency and inferiority, deprived of power (hooks, 2001).

Contrary to popular belief, Black women have for decades, individually and collectively, engaged in resistance against systems of oppression (Collins, 1990). Collins further argues that black feminist thought presents Black women not as victims, but as self-reliant, self-defined individuals who confront race oppression on a daily basis. Despite deliberately erected barriers, and in the face of derogatory stereotypes and misconceptions, the evidence is clear that, from the period of slavery to the present time, Black women have played a significant role in advancing their social and political empowerment and liberation from various oppressions. As Daniel (2003) states:

Black women have simply not been content to play a secondary role in the Black freedom struggles or to settle for anything less than the right to fulfill their dreams and aspirations as Black women free of prejudices, misconceptions and constraints of patriarchy and male domination (p.2).

Collins (1990, 2000) maintains that knowledge is a major factor for empowerment. She argues that when subordinate groups acquire knowledge about their experiences with oppression, it can be empowering and subsequently lead to strategies for their liberation. Collins (1990) also suggests that there are far greater implications derived from "...new ways of knowing [which] allow subordinate groups to define their own reality..." (p. 222). Collins (2000) posits that Black women are "...legitimate agents of knowledge. No longer [are they] passive objects of knowledge manipulated within prevailing knowledge validation processes..." (p. 266). Seen in this context, Black women are proactively speaking for themselves about themselves, as in the case of seven Black and one Filipino nurse who charged racism against their employer -- Northwestern Hospital in Toronto -- and received a human rights settlement of \$320,000 (OHRC, as cited in Hagey et al, 2001). In so doing, they brought to public attention the bitter realities of many racialized minority nurses. These women speaking out subvert

the dominant discourses that misrepresent their realities and work experiences.

Regrettably, the study by Hagey et al (2001) found that there are negative consequences for nurses who break the silence and speak out against racism and racial discrimination in nursing.

In the context of this research, the black feminist discourse provides a way to deconstruct Eurocentric theorizing and the denial of Black women's experiences. The black feminist perspective also looks to the possibility of rupturing the falsities of negative stereotyping of Black women that contribute to their continued subjugation in Western societies.

Integrative Antiracism

The purpose of this section is to present the key themes related to integrative antiracism that were utilized in this study for analysis of the respondents' narratives about their experiences in predominantly White management workforces. The decision to engage an antiracist discursive framework for analysis in this project is primarily because the research addresses the realities of Black female nurse leaders in healthcare workplaces that are covertly driven by issues related to race. Utilizing an antiracist discursive framework is paramount to this project, which engages in decisive and integrated analyses of issues of race and racism...issues that, in part, contribute to racist and hegemonic workplaces for the research participants.

The theoretical perspectives of integrative antiracism used in this project draw on the existing works of Dei (1996, 2000), and Calliste (1996, 2000). Although an anti-racism discourse validates the interrelatedness of race, gender and class in shaping

women's experiences, Dei & Calliste (2000) further argues that "A genuine anti-racism "project" [as in the case of this research] demands space for race to be analyzed outside of class and gender, so that race is reduced to neither class nor gender" p. 15). Dei & Calliste (2000) suggests that highlighting race as a central element in any antiracist dialogue is explicitly political. In other words, the political stance of antiracism calls for race to be centered and, "...its salience is primary even when other dimensions of oppressions co-exist with racial ones" (p. 15). It is noteworthy that Dei's and Calliste's assertion is supported by the findings of the present study and previous studies' findings that show Black nurses' perceived race was the main factor in determining their everyday experiences of prejudice in the workplace. However, in so doing, it is not intended to lessen the importance of other categories of difference.

Dei (2000) posits that integrative antiracism "...offers both theoretical and practical responses to the challenging questions about the nature and practices of race and racism and the intersections" (p. 24). The politics of antiracism embrace the notion of social change, and challenge hegemonic structures within society. Accordingly, Dei (1996) also argues that, "...antiracism is an action-oriented, educational and political strategy for institutional and systemic change that addresses the issues of racism and other interlocking systems of oppression (sexism, classism, heterosexism, ableism" (p. 13). By this definition, it is important to centre race in an antiracism discourse because it is politically necessary to initiate action. In the context of the current research, the participants mentioned the need for change in their respective workplace environments to improve relations between themselves and their White colleagues.

Dei & Calliste (2000) asserts that, "...a critical antiracism discursive framework deals foremost with equity" (p. 17). This is particularly relevant to this study on Black female nurse leaders, because it provides the interpretive lens for analysis of how the politics of race has created power inequities between Black and White nurses. Although earlier research suggests that Black and other racialized female nurses rarely advance into administrative and leadership roles, this project focuses on a sample of Black nurses occupying these positions. This might make it easy to argue that racism is not a reality in nursing; otherwise, these women would not be in positions of leadership. On the contrary, previous research participants perceived that they did not share the same level and kind of power as their White counterparts because of the pervasiveness of racist ideologies that influenced power structures and leadership dynamics.

As Dei (1996) points out, anti-racism theory questions dominant power and privilege, and the rationality for dominance in society. Integrative antiracism discourse is particularly relevant to this study to analyze the power dynamics and structures within the nursing profession, where power is organized around the notion of race. The embodiment of White racial identity is linked to notions of power and privilege. On the other hand, Black identity is linked to marginality and disempowerment (Dei, 1996). Dei further mentions that it is not that one group [Whites] has power and Blacks do not, but rather Black people have agency to claim their racial identity which, in turn, can be empowering.

Research Questions

The main argument of this study is that racialization phenomena create unique experiences for Black female nurses, particularly those in leadership positions. Based on the aforementioned theoretical framework, the project will address the following central research questions:

1. From the perspectives of African Canadian women, what, if any, are the key barriers and challenges encountered in management level positions?
2. How does race impact the everyday experiences of African Canadian women nursing leaders and determine how managerial ability is understood?
3. What strategies do African Canadian female nurses in management positions use to maintain their personal and professional integrity in the workplace?
4. What strategies and actions are needed to diversify the nursing workforce at all levels within and beyond Metropolitan Toronto?

Summary

This chapter reviewed key theoretical concepts of black feminism and integrative antiracism, and discussed their relevance and application to the thesis subject. It also outlined how the two perspectives converge in the analytical framework that was used in the research to clarify how race determines the workplace experiences of Black women.

The next chapter describes the research methodology and outlines the methods used in the study for participant recruitment and data collection and analysis.

CHAPTER FOUR

RESEARCH METHODOLOGY

Introduction

This chapter describes the methods used in this research to investigate, analyze and interpret Black nurse leaders' experiences in the healthcare workplace. The chapter further explains the rationale for using qualitative methodology, and an overview of phenomenology is presented. Each of the sixteen study participants are introduced and briefly profiled in terms of their background, level of education and nursing leadership experience. Finally, associated ethical considerations, risks and benefits are discussed, and the process for securing the research data is outlined.

Study Design

Qualitative research methodology is arguably under-utilized in fields of study such as medicine; nonetheless, it has a long history in the social sciences (Pope & Mays, 1995). The review of literature on qualitative research suggests there is no single definition. Creswell, as cited in Coates (2004) remarks:

Qualitative research is an enquiry of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting. (¶. 3).

Mathie & Camozzi (2002) make the point that:

Often qualitative research is described by the methods most associated with it, such as participant observation, in-depth interviews or the case study. In fact, qualitative research is more than just method; it is a particular *approach* to inquiry, based on a particular set of assumptions about how knowledge is produced and about the nature of reality itself (p. 25).

Cassell & Symon, as cited in Kohlbacher (2006), outlined the characteristics of qualitative research as:

...a focus on interpretation rather than quantification; an emphasis on subjectivity rather than objectivity; flexibility in the process of conducting research; an orientation towards process rather than outcome; a concern with context—regarding behaviour and situation as inextricably linked in forming experience; and finally, an explicit recognition of the impact of the research process on the research situation (p. 7).

Over the years there has been considerable debate among scholars about the rigor and scientific validity of qualitative and quantitative research approaches. Some scholars contend that qualitative research is less rigorous compared to quantitative research (Coates, 2004). In fact, it has been argued that qualitative research is “nonscientific and thus invalid” (Berg, 2007, p. 3). Pope & Mays (1995) posits that qualitative research “...is viewed as the antithesis of the quantitative method...the two approaches are frequently presented as adversaries in a methodological battle” (p. 42).

It is well established that quantitative research approaches are rooted in numbers and objective data, and generally require a large sample size to arrive at findings and conclusions with a high level of accuracy (Maxwell, 1996). In addition, Berg (2007) argues that because “quantitative research relies chiefly on numbers; many people erroneously regard quantitative strategies as more scientific than those employed in qualitative research” (p. 4). By contrast, qualitative research approaches go beyond numbers and statistical accounts to examine the patterns of meanings that emerge from the respondents’ interview data, in order to gain an understanding of their subjective viewpoints or feelings about the human dimensions being studied (Berg, 2007; Jaye, 2002; Maxwell, 1996).

While some scholars participate in ongoing debates about the accuracy and relevance of qualitative research methodology in knowledge production, Kohlbacher (2006) argues that the qualitative approach is best used when exploring the details of people's lived experiences, in order to maintain the authenticity of their stories.

It is my belief, and the belief of other scholars (Berg, 2007; and Maxwell, 1996), that qualitative and quantitative methodological approaches are both valuable research strategies, each having different strengths and limitations. A qualitative approach was selected for the current project because it allows for a thorough exploration and analysis of the research topic under examination. Liehur & Marcus (1994) point out that, "The researcher using this approach believes that unique humans attribute meaning to their experiences and experiences evolve from life context" (p. 257). I concur with other scholars (Richards & Schwartz, 2002; Van Mannen (1990) who claims that qualitative research methods are best employed to explore and analyze the details of people's lived experiences.

Qualitative research that moves beyond factual accounts typically deals with a small sample size and produces a subjective analysis (Maxwell, 1996); hence, qualitative findings cannot be directly generalized to the population. However, in the traditional quantitative sense, they justify statistically-based conclusions about observations in a qualitative context. Although the contextualized subjectivity of qualitative inquiry may be considered a limitation, nevertheless researchers use this approach not to generalize the research findings, but rather to understand individuals' experiences and the uniqueness of their responses (Jones, 2002).

Coates (2004) suggests that the flexibility of qualitative research is seen as a weakness when compared to the use of stringent predetermined schedules designed to eliminate bias in quantitative research. However, the strengths of the qualitative approach must not be understated. Harris (2003) and Riggs (1998) suggest that a key strength of qualitative research is the rich and extensive data that it generates. Based on the nature of the research topic examined in this dissertation, I wholeheartedly believe that capturing and reporting the richness of the beliefs that imbue the expansive data generated in the study necessitates using a qualitative method.

Because of the complexity inherent in the present research topic and the important questions being addressed, it is my belief that a qualitative approach is particularly appropriate for studying and providing a deeper insight into the participants' experiences (Maxwell, 1996). The literature identifies various qualitative approaches...the five main methods can be classified as: phenomenology, grounded theory, ethnography, the case study and historical. Based on an in-depth analysis of the potential strengths and limitations of the available qualitative research methodologies, I decided to use a phenomenological approach to accomplish the specific research objectives. Therefore, a qualitative study employing a phenomenological approach was undertaken to understand the experiences of Black female nurse leaders in the healthcare workplace.

Phenomenology as a research method will be addressed later in the chapter.

Another reason for selecting a qualitative research design for the current study is because it leads to an in-depth understanding of the research issues, "...including an exploration of the reasons and context for participants' belief and actions" (Richards & Schwartz, 2002, p.136). Additionally, this specific methodological approach *was* chosen

because it enables me to describe, in a meaningful and detailed way, the participants' perspectives about their experiences, and the meanings they give to their experiences (Hancock, 1998; Hilton, 2002; Miller & Jezewski, 2001; Myers, 1997). Without doubt, this methodological approach provides the tools that enable me to relate the participants' stories in a way that maintains their authenticity, while also revealing the deeply layered meanings of their narratives.

Lastly, "A major strength of the qualitative approach is the depth to which explorations are conducted and descriptions are written, usually resulting in details for the reader to grasp the idiosyncrasies of the situation" (Myers, as cited in Neill, 2006, ¶. 14).

Phenomenology: Historical Developments

It is not my intention to present a detailed account of the history of phenomenology in the present thesis, but rather a brief overview of its evolution, followed by a more detailed examination of the interpretive and descriptive phenomenological approach used in the present study.

The phenomenological perspective of science grew out of the critique of positivism and its inappropriate application to human concerns (Lavery, 2003). The literature identifies Husserl, Sartre, Heidegger and Merleau-Ponty as four of the better-known philosophers of phenomenology. Over the years, various interpretations of Husserl's philosophical work have resulted in many types of phenomenological methodology, including hermeneutic, transcendental constitutive, naturalistic

constitutive, existential, generalist historical, genetic and realistic (Woodruff Smith, 2003).

“What is phenomenology”? The question is asked repeatedly by all who attempt to develop some understanding of this philosophy. According to Woodruff Smith (2003):

Phenomenology is the study of “phenomena”: appearances of things, or things as they appear in our experiences, or the ways we experience things, thus the meanings things have in our experience” structures as experienced from the first-person point of view (§. 3).

Phenomenology identifies that there is another way of being in the world, which is separate from the biological aspect of being human. From a phenomenological perspective, dimensions of human life are recognized as autonomous, and a new basis of cognitive evaluations is established (F. Wynn, personal communication, October 21, 1996). Phenomenology represents a drastic shift from the positivist tradition as exemplified in the empirical natural science approach (Cohen, 1987).

Using a phenomenological research approach allows for persons to be studied in the situation, which is a way of knowing and being, and not in the context of a mere object or biological, psychological or sociological components. Phenomenology maintains that there are other forms of knowledge in addition to those evidenced in formal and natural science. This approach to science seeks to provide answers to important questions of deep human concern -- those that deal with the world of lived experiences that is not accessible through the natural sciences (Cohen, 1987). Lavery (2003) points out, “Phenomenology is essentially the study of lived experience...” (p. 4).

A lived experience is how a person immediately experiences the world pre-reflectively. Humans are always changing and constructing meanings from many levels

of the universe in the co-creating of what is real (Parse, 1992). It has been argued that with each situation encountered, many possibilities unfold, and with the accumulation of experiences, the person's life becomes intricate with many layers of meanings (Parse, 1992). In contrast to the cold mechanistic view of persons associated with positivism, the use of phenomenological language allows for human phenomena to be described from a humanistic perspective. Dreyfus (1991) claims that researchers' interest in interpretive methodology is because it takes into account meaning and context.

Liehur & Marcus (1994) point out that phenomenology as a qualitative research method "...is a process of learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience" (p. 262). These authors suggest that, "Because the focus of the phenomenological method is lived experience, the researcher is likely to choose this method when studying some dimension of day-to-day existence for a particular group or individuals" (p. 262). Woodruff Smith (2003) posits, "...in the practice of phenomenology, we classify, describe, interpret, and analyze structures of experience in ways that answer to our own experience" (¶. 22). For all the aforementioned reasons, phenomenology is the most appropriate method for the present research study.

Method

This qualitative study uses a hermeneutic phenomenological approach.

Hermeneutic phenomenology, according to Van Manen (1990):

Tries to be attentive to both terms of its methodology: It is a *descriptive* (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an *interpretive* (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena. (p. 180).

Van Manen (1990) proposes a methodological approach that consists of six research activities for hermeneutic phenomenological research:

- 1) turning to a phenomenon which seriously interests us and commits us to the world;
- 2) investigating an experience as we live it rather than as we conceptualize it;
- 3) reflecting on the essential themes which characterize the phenomenon;
- 4) describing the phenomenon through the art of writing and rewriting;
- 5) maintaining a strong and oriented pedagogical relation to the phenomenon;
- 6) balancing the research context by considering parts and whole (pp. 30-31).

The aforementioned research activities were undertaken for the present research.

The first activity I engaged in is identifying the phenomenon to be explored, and this subsequently led to developing the research question. My personal experiences, and those of other Black women in nursing, created a desire to fully understand the experiences of Black female nurse leaders in a predominantly White workforce. As Maggs-Rapport (1999) explains, "...initial understanding of the phenomenon does not have to be highly developed but there must be some knowledge about the area of inquiry" (p. 221). To acquire further understanding of the phenomenon under investigation, I submersed myself in the limited available literature and scholarship with the goal of

acquiring in-depth knowledge and insight into the phenomenon. In addition, conversations with nursing colleagues confirmed the need for an empirical examination of the issues confronting Canadian Black nurses in leadership positions. Van Manen (1990) mentioned:

... [t]he problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much. Or, more accurately, the problem is that our “common sense” pre-understanding, our suppositions, assumptions, and the existing bodies of scientific knowledge, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question (p. 46).

Van Manen (1990) points out that bracketing is an essential component in phenomenology research. Polit & Beck (2004) define bracketing as “...the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study” (p. 253). It is argued that bracketing is necessary to allow new knowledge to generate without the influence of the researcher’s prior knowledge and possible biases related to the phenomenon (Thorne, 2000). And yet, it could be argued that it is virtually impossible to completely suspend all prior knowledge, biases and assumptions about any phenomenon. To the degree possible, I strove to suspend prior beliefs about the phenomenon under investigation.

Setting and Sample

The population of interest for the current phenomenological study is comprised of self-identified Black women, employed as nurse managers, or nurse administrators/executives who had previously worked as nurse managers within the last five years. The criteria for participation in this research study were: self-identified; currently employed as a nurse manager and in the position for more than six months; or

having previously worked as a nurse manager but not out of the role for more than five years; an ability to write and speak English; and consenting, voluntarily, to participating in the study. Women out of the nurse manager role for more than five years were not invited to participate because their past work experiences may not be representative of the current situations in the healthcare workplace.

Sample Selection

As mentioned elsewhere, a cohort of Black women in the nursing profession was selected for my research project because anecdotal accounts, empirical evidence and personal experiential knowledge suggested that these women's everyday experiences are distinctively shaped by race oppression, and are different than the experiences of Whites and other women of colour. The OHRC (1997) points out that Black women experience racial discrimination in completely different ways than other racial minority women or men. Although this study focuses exclusively on Black women, it is not my intention to imply that other women of colour do not experience racism in Canadian nursing.

For this study, all the participants, African Canadian female nurse leaders, were recruited from various healthcare settings to share information about their work experiences as nurse leaders. To facilitate recruitment, the study was conducted in Metropolitan Toronto, which has the largest Black population in Canada. The recruitment process began the second week of May 2005, after approval by the University of Toronto Human Subjects Review Committee. Potential study participants were sought in a variety of healthcare facilities — hospitals, long-term care facilities, public health units and community care access centers.

A detailed letter explaining the purpose of the study was sent by e-mail to the human resources departments of forty-six healthcare facilities in Metropolitan Toronto. (*See Appendix: Information Letter for Human Resource Departments.*) The healthcare facilities were asked to assist by distributing the letter to potential recruits. Six of the forty-six healthcare organizations did not receive the letter due to incorrect e-mail addresses. Thirty-six of the remaining forty healthcare organizations failed to respond to the information that was forwarded although the email addresses were correct. Ultimately, only four organizations confirmed by return e-mail that the information had been received by their human resource departments. Of these four, two denied having staff who met the study criteria, and one organization questioned why it was approached. Despite my detailed explanation, my request for the research information to be given to potential participants was turned down. One of the four organizations indicated that senior management approval had to be obtained before the information letter could be distributed within the organization. Two weeks later, a representative from senior management granted approval. Consequently, the information was posted on the general notice board at the facility for a specified period of time, and sent to senior managers to disseminate to their staff. In spite of these efforts, only one participant was recruited through the aforementioned process.

To address this recruitment shortfall, I adopted a snowball sampling strategy, whereby colleagues and friends were approached and asked to refer potential recruits for the study (Streeton, Cooke, and Campbell (2004). (*See Appendix: Study Information for Individuals who may be Interested in the Study.*) According to Berg (2007), snowball sampling involves first identifying several people with relevant characteristics, and

interviewing them or having them answer a questionnaire. These subjects are then asked for the names (referrals) of other people who possess the same attributes -- in effect, a chain of subjects driven by one respondent's referral of another (p.14). Using a snowball sampling technique proved beneficial, as it provided a means of accessing participants where they are few in numbers (Atkinson & Flint, 2001; Berg, 2007).

For the current study, twenty potential participants were referred by nurse colleagues and friends. Three of the women could not be reached in spite of my numerous attempts to contact them by telephone and e-mail; the remaining seventeen were contacted by telephone, provided with detailed information on the study and encouraged to ask questions about the research. As well, efforts were made to speak with those who were hesitant to participate, and to answer any of their questions.

All the nurse leaders who met the study criteria were sent a letter inviting them to participate, and were provided with details including the expected duration of the interview, a copy of the interview question guide and a biographical questionnaire to be completed prior to the interview. Two women, who had expressed willingness to participate, had to decline because of scheduling conflicts and for unstated personal reasons. In total, sixteen women agreed to participate in the study, and their informed consent was obtained before data was collected. (*See Appendix: Letter of Informed Consent*). Individual interviews were scheduled at a time and place convenient for each participant.

It is important to note here that because this is an in-depth qualitative research project, the sample size is intentionally small. As Cuadraz & Uttal (1999) point out, "The power of small samples to theorize socially significant issues should not be overlooked"

(p. 166). Based on the above assertions, it is my opinion that the sample size is adequate considering that the target research population in the Metropolitan Toronto region is relatively small. As the researcher, I was very much aware that it would be difficult to recruit participants because of the controversial and somewhat sensitive nature of the issue addressed in the study.

Data Collection

There are various qualitative methods of data collection (Berg, 2007; Maxwell, 1996). Data for the current study was collected from each participant using a self-administered questionnaire, and through individual interviews. The questionnaire consisted of three open-ended and numerous closed-ended questions, compiled specifically for this research project (*see Appendix F: Biographical and Demographic Data Form*). It also requested information about career histories and professional responsibilities, to establish a profile of each woman, and an overall profile of the group. (*Full details of the biographical and demographic data of the study sample are displayed in Table 2.*)

The interview is one of the most widely utilized qualitative research tools, and the most appropriate approach for the current research (Berg, 2007; Maxwell, 1996). Cuadraz & Utal (1999) mention that “The more common practice for in-depth interview studies is to study small homogenous samples in order to achieve an in-depth understanding of particular lived experiences” (p. 162). According to Yoder (2001), “The major advantage” of a semi-structured in-depth approach “...over a structured interview is that it allows the person interviewed to participate in choosing what to

discuss, and thus influence what elements are considered relevant to the situation...” (p.

8). Cuadraz & Utall (1999) add:

...in-depth interviewing encouraged individuals to explain how they viewed their circumstances, to define issues in their own terms, to identify processes leading to different outcomes, and to interpret the meaning of their lives to the researcher, rather than merely identifying the outcomes (p. 160).

Semi-structured, in-depth one-on-one interviews were conducted with the sixteen participants in this study, and a cassette tape recorder was used to record all verbal interactions between the researcher and the participants during the interviews. The interviews were conducted at locations that were mutually convenient and comfortable for the participants and the interviewer, with most occurring at participants' workplaces, and a few held in participants' homes.

Prior to beginning the interviews, I reviewed the purpose of the study with each participant, and encouraged them to ask any questions regarding the process. Each was invited to be as forthcoming and detailed as possible. The expected duration of the interview (1-1½ hours) was reiterated. All indicated they were comfortable having their answers tape-recorded.

A semi-structured qualitative interview format is appropriate in this study “...for creating an informal atmosphere conducive to the free expression of ideas [and} allowed for probing and clarification of responses...” (DeRoeck, 2004, p. 324). This format, according to literature is the most commonly used method of data collection in qualitative research, for the purpose of probing the ideas of research participants.

The main purpose for conducting semi-structured, one-on-one interviews was to explore the participant's experiences as Black nurse leaders in their workplaces, various healthcare organizations and settings across Metropolitan Toronto. Aided by twelve

open-ended interview questions that were developed specifically for this project, I gleaned the participants' perspectives and feelings about the research topic. Because the research topic could be considered 'sensitive' in nature, a one-on-one interview approach was preferred over group interviews because it allowed participants to: 1) openly share confidential information and talk honestly about their experiences; 2) take advantage of a safe space to talk about their experiences of discrimination and racism; and 3) not be influenced by the opinions and responses of other participants.

Because this study uses a phenomenological approach, the interview questions were constructed to query the lived everyday experiences of the research participants in their workplace settings (Liehur and Marcus, 1994).

For example, participants were asked the following questions: "Does race affect how you function in your role? Why or why not? If so, in what ways?" Liehur & Marcus (1994) mentioned, "When the question is asked of the participant, it frequently takes the form of a statement" (p. 262). An example of a question asked in the current research in the form of a statement is: "Please tell me about any experiences you might have had that made you wonder if you were being treated differently in your role as nurse manager."

The interview questions (*Appendix G: Interview Guide*) were organized under main themes, and further divided into sub-themes. A general open-ended question about the participants' experiences in the workplace was asked first to elicit their perceptions about being treated differently than White colleagues. Answers to this question often provided further in-depth explanations and clarification of the participants' narratives. Additional questions sought information regarding the effects of racism on the

participants' work performance and personal wellbeing, their resistance and coping strategies and their suggestions for positive changes in the workplace.

During the interviews, some respondents occasionally drifted from the topic, and it was therefore necessary to refocus the conversation by repeating or reframing the research question. As well, some of the participants provided short answers to the interview questions, and needed to be encouraged to respond in more detail. Others, however, were effusive and continued to provide information after the interview ended and the recording was stopped. During the interviews, and with the participants' consent, summary notes were taken to augment the taped responses, and to document the researcher's perspectives of the interview process. Upon completion of the interview, all study participants were thanked for their participation in and contribution to the research. All gave their permission for follow-up telephone contact by the researcher, if and when necessary.

Summary Demographic Characteristics of Participants (N=16)

Fifteen nurse leaders completed the questionnaire, and sixteen participated in an individual interview. Baseline demographic data were collected at the time of the interview from participants including age, place of birth, birth order, parents' birth place, highest level of education attained, place of education, related professional activity, career interruptions, other leadership positions held in Canada and number of years in leadership positions. One participant of the total sample (N=16) did not complete the biographical and demographic data sheet, and those who completed the questionnaire (N=15) did not respond to all the elements that are listed.

The majority (13/16) of participants were born in Jamaica, one in Trinidad, one in Barbados and one in St. Lucia. The final sample for this study consisted of 16 self-identified Black Canadian women, ranging in age from 38-62 years, with a mean age of 51. Two respondents did not indicate their age; one respondent reported a mature age.

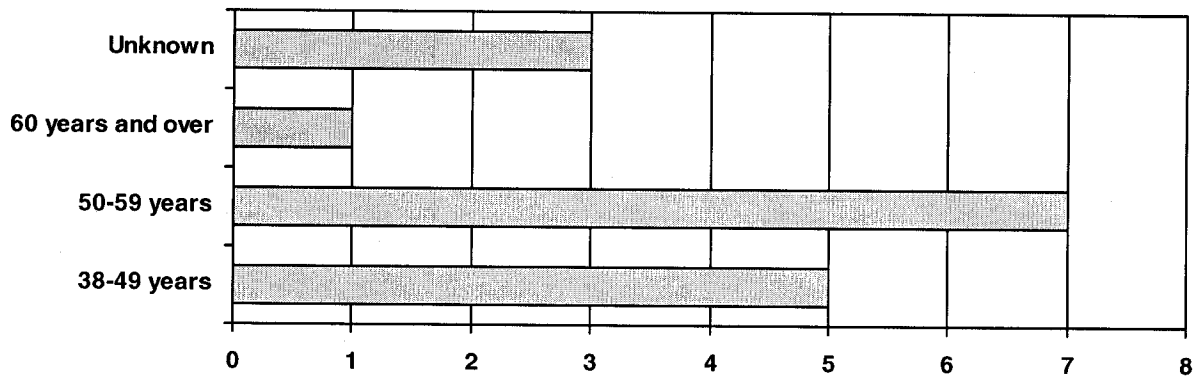


Figure 3.1 Summarizes the findings relating to the participants' ages

The participants were asked about their highest level of education. The results were that 13 of the 16 participants have Master's degrees: one in health administration, two in education and the others in nursing. Of these, three participants were pursuing Doctoral degrees -- two in health policy, and one in nursing. One of the participants has a Doctorate in nursing, and two have Bachelor's of nursing science degrees.

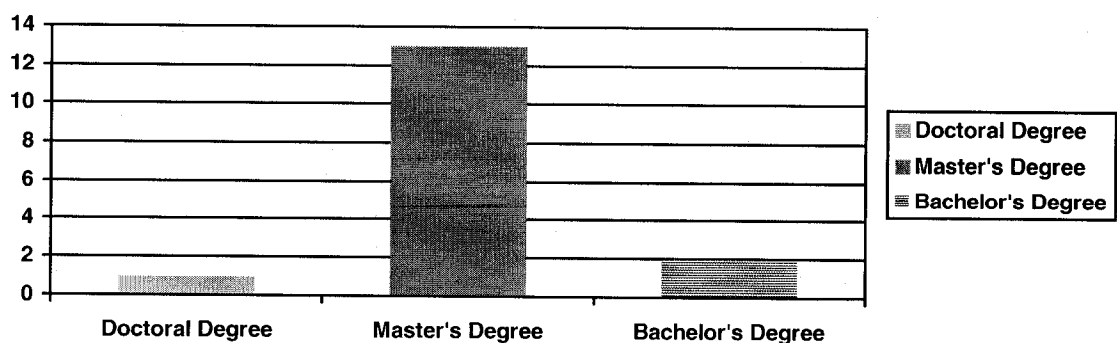


Figure 3.2 Summarizes the findings relating to the participants' highest level of education

Of the total sample (N=16), ten currently work as nurse managers; three are directors of nursing who previously worked in nurse manager positions; one participant is employed as a nurse executive and has worked as a nurse manager; one participant is a clinical coordinator with responsibilities similar to a nurse manager; and one participant is employed as a nursing supervisor with responsibilities similar to a nurse manager. All the participants, at the time of the study, were employed full-time.

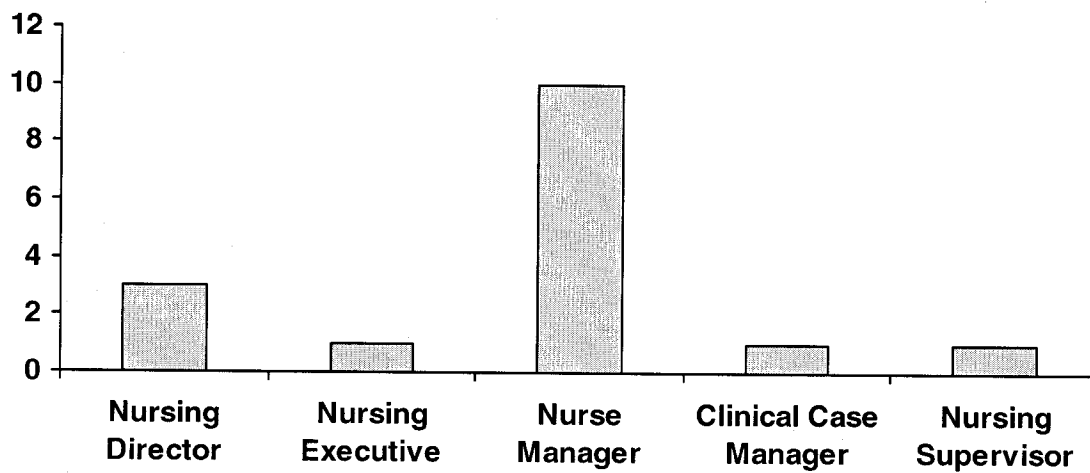


Figure 3.3 Proportion of participants by current employment

Detailed characteristics of the study sample are shown in Table 1.

Pseudonym	Category				
	Country of Origin	Age Range	Current leadership positions	Total years in nursing leadership	Highest level Education
Susan	Trinidad	52 to 59	Nurse Manager	20 or more	PhD
Lynne	Jamaica	54 to 59	Director of Nursing	15 or more	Master's
Elizabeth	Jamaica	50 to 59	Nurse Manager	10 or more	Bachelor's
Heather	Jamaica	38 to 49	Nurse Manager	10 or more	Master's
Margaret	Jamaica	40 to 49	Clinical Coordinator	10 or more	Master's
Lucy	Jamaica	50 to 59	Nurse Manager	10 or more	Master's
Jeanette	St Lucia	Mature	Nurse Executive	20 or more	Master's
Diane	Jamaica	58 to 59	Nurse Manager	20 or more	Master's
Martha	Jamaica	50 to 59	Nurse Manager	10 or more	Master's
Linda	Jamaica	51 to 59	Nurse Manager	20 or more	Master's
Alison	Jamaica	46 to 49	Director of Nursing	10 or more	Master's
Gwen	Jamaica	60 to 65	Nurse Supervisor	8 to 10	Bachelor's
Pamela	Jamaica	47 to 49	Nurse Manager	10 or more	Master's
Mary	Barbados	46 to 49	Nurse Manager	10 or more	Master's
Gloria	Jamaica	Unknown	Nurse Manager	8 to 10	Master's
Christine	Jamaica	Unknown	Director of Nursing	15 or more	Master's

Table 1. Background information: Detailed characteristics of study sample

Nurse Manager Participant: Susan

Susan was the first nurse manager to participate in an individual interview and complete a questionnaire. She immigrated to Canada from Trinidad, and has lived in Canada for many years. Susan holds a Doctoral degree in nursing. She has been in nursing leadership positions for close to twenty years, and has worked in her current position for five years. She has also worked as an instructor of nursing students.

Susan currently works as a nurse manager in a community-based healthcare setting. In this position, she provides leadership supervision to sixteen full time staff. As well, she is responsible for budget preparation, and facilitation, implementation and evaluation of program and policy development. She also coordinates nursing student placement, and acts as mentor and coach to students and staff. Additionally, Susan facilitates the development of research, and promotes the utilization of research in nursing practice.

Susan enjoys many of the functions of her current role in nursing administration, but indicated that some of her administrative skills and knowledge are not valued in her workplace. She is a born-again Christian who shares her faith and beliefs openly. During the interview process, Susan repeatedly mentioned that her faith and belief in God sustained her during difficult times in the workplace. She was extremely engaged in the interview process, and spoke candidly about her experiences of racism during her nursing career. Susan spoke with confidence about her ability and regarding her competency as a nurse leader in her workplace environment. My field notes indicated that the interview went very well, and most importantly Susan and I felt very comfortable during the interview process. This awareness was extremely important for me because the interview was the first to be conducted, and also because Susan was knowledgeable about the process having conducted her own doctoral research.

Nurse Manager Participant: Elizabeth

Elizabeth currently works in a leadership position in nursing education, the only child of Jamaican-born parents. She migrated from the Caribbean at an early age, and lived in England before immigrating to Canada. She is married and has a family. Elizabeth was educated in Britain and Canada. She started her nursing career as a Registered Practical Nurse, and then returned to school to complete her registered nurse training. She currently holds a Bachelor's degree in nursing. Elizabeth has worked for many years at her present place of employment, several of those years as an acting nurse manager.

In her role as an educator, Elizabeth promotes quality nursing practice by supporting and facilitating educational activities. Although she finds her current job very stimulating, nonetheless she is concerned that, in her organization, there are relatively few Blacks in formal leadership positions, and none in formal nursing leadership roles such as nurse manager. There have been no interruptions in Elizabeth's career.

Nurse Manager Participant: Heather

Heather is a nurse manager who immigrated to Canada from Jamaica. She is the second child of parents who were also born in Jamaica. Heather is married but does not have a family of her own. She is the youngest of the nurse managers who participated in the study, and holds a Master's degree in nursing.

Heather worked as a clinical case manager in a large acute care facility for nearly two years before she became a nurse manager in the same institution. She has been in her current role as nurse manager for close to eight years. In her current position, Heather

provides leadership and direction to a large nursing and support staff, in accordance with organizational and departmental goals and objectives. She also maintains an environment that encourages quality patient care and values staff satisfaction. Heather is very much aware of the challenges Black and other racialized women nurse leaders encounter in the work environment.

Because Heather manages a very busy patient care unit, her interview occurred over several days. Consequently, Heather and I were forced to reestablish the researcher/participant relationship at each encounter. Nonetheless, she was committed to completing the interview, and indicated the process enabled her to acknowledge and speak about some extremely painful experiences.

Clinical Coordinator Participant: Margaret

Margaret is a clinical coordinator who participated in an individual interview and completed a biographical and demographic questionnaire. She immigrated to Canada from Jamaica. The first of four children for her mother, and the second of five children for her father, Margaret did not divulge her marital status or whether she had children.

Margaret holds a Master's degree in nursing from the University of Toronto. She has worked as a nurse for over 16 years, and for the last five years as a clinical coordinator in a large acute care organization. Margaret heard about the study from a nursing colleague, and enquired about participating. Because she was not in a nurse manager role, it was questionable if she met the inclusion criteria. This issue was discussed with my research supervisor and committee members, and the decision was reached to include her in the study.

Margaret says the functions and responsibilities of her role as a clinical coordinator are similar to those of a nurse manager, with the exception of budgetary responsibilities. As a clinical coordinator, her duties include coordination of patient services and clinic and staff schedules, and the development and implementation of educational programs for nurses and patients and their families. Margaret indicates that the functions of the clinical coordinator role are diverse, subject to change as circumstances dictate, and vary according to the perspective of upper management and subordinates.

Margaret also has had a concurrent interest in medical records management for the past several years, but is not ready to leave the profession of nursing entirely. She participates in various public speaking activities and conference presentations, and is an active member of several work-related committees. Margaret was enthusiastic during the interview, and talked candidly about the challenges of being in an informal leadership role.

Nurse Manager Participant: Lucy

Lucy is a nurse manager participant who took part in an individual interview and completed a questionnaire. Born in Jamaica, she immigrated with her parents to Canada at a young age. Lucy holds a Master's degree in nursing, and is completing a Doctoral degree in nursing. She is married and has three grown children.

During her nursing career, Lucy has held several positions with increasing leadership responsibilities in a large acute care setting. These include clinical case

coordinator, nurse educator and nurse manager. All her leadership positions have been in the same organization.

Lucy's first leadership role was as a clinical case coordinator, a position she held for close to five years. She then worked in the nurse educator role for a couple of years. For the past five years, she has worked full-time in the nurse manager role.

In her current position, Lucy manages a large staff consisting of nurses and clerical and service workers. She has responsibility for patient care and professional practice standards, staff development and the day-to-day management of and service delivery for the patient care unit. Lucy is deeply interested in nursing education, and for over six years, she has been teaching part-time. She also has a passion for mentoring and coaching nursing students in the profession. Lucy is also actively involved in several professional associations and community-based organizations.

Nurse Manager Participant: Diane

Diane holds a Master's degree in education. Her nursing career includes more than twenty years in leadership positions. She has worked as a nurse manager in four different healthcare organizations.

The first three facilities were acute care settings, and the most recent is a long-term care facility. In her current role, Diane leads, supervises, and manages a large staff of registered nurses and support people. She has multiple responsibilities including supervising the coordination of patient care, ensuring the quality of nursing care, hiring and developing staff, and preparing and managing budgets.

Prior to her present position, Diane worked as a nurse educator for three years. She indicated she went into nursing education because of her love of teaching and watching young nurses grow into competent professionals. She further mentioned that she was drawn back to the nurse manager's position because she enjoys the administrative aspects of the role such as budgeting, program development and human resource management. Diane is involved in numerous professional nursing and community-based organizations.

Nurse Manager Participant: Martha

Martha, a nurse manager in a large acute care organization, agreed to participate in an individual interview and complete a questionnaire. She immigrated to Canada from Jamaica, and holds a Master's degree in nursing from the University of Toronto. Prior to her current position as nurse manager, she spent 5 years working as a clinical coordinator.

In her role as nurse manager, Martha actively provides leadership to a large staff consisting of nurses and clerical and service staff. Her responsibilities include managing the delivery of patient care, service coordination, program planning and human resource management. Martha is also involved in professional nursing activities outside her workplace.

Martha enjoys her current position as nurse manager, but admits to experiencing challenges that she attributes to issues of race and racism in the workplace environment. She is a light skinned Black woman, who could pass as a White person. This factor was discussed in the interview, but Martha affirmed her belief that she is recognized as a Black person. From her perspective, she is seen as "non-Black" more by Blacks who are

of darker complexion, who tend to question whether she is Black or not. On the other hand, she is considered to be a Black person by Whites.

Martha does not believe her light skin colour protects her from experiences of racism. However, she does believe she is treated differently, in a positive way, by people who know her partner is in the medical profession. She attributes this differential treatment to class privilege.

Nurse Manager Participant: Linda

Linda is a nurse manager in a large acute care facility, who holds a Master's degree in education. She immigrated to Canada from Jamaica as a young adult. The first born of five children for her parents, both of whom were born in Jamaica, Linda herself is married with two children.

Linda has held several nursing leadership positions, including nurse manager, education director and clinical coordinator, for a total of twenty-two years in leadership roles in various institutions. She has been in her current position as nurse manager for seven years. She manages a large staff consisting of nurses and clerical and support staff.

Linda provided a detailed written job description from her organization. In essence, her responsibilities include, "...planning and operations, human resource management, professional practice and staff development, and customer service and community relations." She also is actively involved in a national nursing specialty association, and participates in the development of the certification exam, as well as being a member of the association for professional nurses in Ontario.

Nurse Manager Participant: Pamela

Pamela is an acting nurse manager in a large teaching facility, and has served in the position for just over one year. Her interview took place at her workplace on a very busy patient care unit. This resulted in numerous interruptions and distractions during the interview process.

Pamela is responsible for an acute care unit and an ambulatory care program. She manages and develops a large multidisciplinary staff consisting of nurses and support workers. She also has responsibility for program planning and management, operational effectiveness and quality outcomes, and the support of corporate and leadership initiatives.

Pamela has served in a number of nursing leadership positions including clinical educator for three years, clinical nurse specialist for three years, program manager for one year and nurse manager for two years -- close to 10 years nursing leadership experience, in both formal and informal positions. Although she enjoys her current job and has been offered the position on a permanent basis, she admits to not wanting to remain in a formal leadership role. She intends to return to an advance practice nurse role, which is an informal leadership position.

Pamela holds a Master's degree in nursing from the University of Toronto. Her contribution to the profession of nursing extends beyond the walls of the healthcare facility in which she works. She has been involved in the activities of several professional associations, including serving on an editorial board, reviewing and preparing manuscripts for publication and developing nursing orientation programs for long-term care facilities in the province of Ontario.

Pamela did not indicate on her questionnaire whether or not she has had any interruptions in her career. The only child of parents who were also born in Jamaica, she immigrated to Canada, is married and has a family.

Nurse Manager Participant: Gloria

Gloria participated in an individual interview and completed a questionnaire. A nurse manager, she immigrated to Canada from Jamaica. Gloria is married, and has a family. Her interview was done at her home, which provided a comfortable setting for the interview.

Gloria holds a Master's degree in nursing. She shared a story about her academic journey, and how she was encouraged to return to school. After taking the advice and earning her Bachelor's degree, she said, "Oh this feels so good...I'm not stopping!" and continued on to her Master's degree. She said she has thought of doing a PhD, but only when she retires.

Gloria has worked as a nurse manager for the last four years; this is her second managerial position. She presently works in a chronic, long-term care facility. She is a Christian, and very active in her church. Throughout the interview, Gloria made reference to her faith and her belief in God, which provided her with the strength to cope with some of her workplace experiences. She showed remarkable insight into her experiences, which she shared openly during the interview.

Nurse Manager Participant: Mary

Mary is a nurse manager who participated in an individual interview and completed a questionnaire. She immigrated to Canada from Barbados. Her parents were born in the Caribbean, one in Trinidad and the other in Barbados. Mary is married and has two children.

Mary holds a Master's degree in health administration. She has worked in a number of leadership positions, including clinical coordinator in an ambulatory care setting, nurse manager, and program director in various organizations and settings. In her current role as nurse manager of a very busy patient care unit in a large acute care facility, she is accountable for the day to day operation of the unit. Her responsibilities include planning and managing the operating and capital budgets, ensuring professional and departmental standards are met, and promoting an environment conducive to safe patient care delivery.

Nurse Manager Participant: Gwen

Gwen is a nurse supervisor, and the oldest nurse participant in the study. Her parents were born in Jamaica, and she was the ninth child for them. She indicated that her eight siblings are all alive and in good health. Gwen immigrated to Canada from Jamaica, and has two grown children.

Gwen holds a Bachelor's degree in nursing, and has been in leadership positions in community-based health services for close to thirty years. She has had two interruptions in her career for maternity leaves.

Gwen worked as an acting director of nursing for one year, and as a supervisor for nearly ten years. In her current position as nurse manager, she supervises a team of nurses, and unregulated healthcare workers. Her responsibilities include program planning and implementation, and evaluation of health promotion programs. She provides training and support to staff, students and community groups and partners.

Gwen is approaching the end of her nursing career, and is contemplating retirement in a couple of years. During the interview, she frequently digressed from the research questions, and needed her attention refocused on the specific topic. She shared very lengthy and detailed narratives about specific experiences she had suppressed during her very long career.

Gwen's genuine warmth and caring personality made it easy to listen to her stories, which were quite fascinating. She shared many interesting insights into the events of a long career.

Director of Nursing Participant: Christine

Christine is a director of nursing, who agreed to participate in an individual interview but did not complete a questionnaire. She immigrated to Canada from Jamaica. Christine holds a Master's degree in nursing and is completing a doctoral degree in nursing. She has been in nursing leadership positions for close to sixteen years.

Christine was a charge nurse for several years on a busy patient care unit in a large acute care facility, and then worked for close to five years as nurse manager on the same patient care unit. She is currently a nursing director in a medium-size healthcare organization, and has been in the role for close to one year. In this position, Christine is

responsible for directing and coordinating nursing and patient care services, maintaining staffing levels and acting as a liaison between the organization's administration and the nursing and support staff. She also allocates and manages the annual operational and capital budgets for several areas within her organization.

Director of Nursing Participant: Alison

Alison is the second nursing director, who participated in an individual interview and completed a questionnaire. She immigrated to Canada from Jamaica. Alison's parents were born in Jamaica, and she is the third child. She is married and has a family of her own.

Alison holds a Master's degree in nursing. She has just over ten years of nursing leadership experience, and has held several leadership positions, including nurse educator for one year and nurse manager for five years, in a large teaching hospital.

In her current role as nursing director in the same facility, Alison is responsible for the overall delivery of nursing and patient care services, personnel management and development, and fiscal and operational oversight for several patient care units, programs and departments. She has many nurses and support staff reporting to her.

Although Alison has experienced racism and discrimination in her role as nurse manager, she believes that through hard work and having the required qualifications she has been able to advance in her career. She has a passion for mentoring frontline staff to achieve their potential, and has mentored several frontline nurses who aspire to formal leadership positions.

Director of Nursing Participant: Lynne

Lynne is the third nursing director who participated in an individual interview and completed a questionnaire. Originally from Jamaica, she immigrated to Canada from Europe. Lynne is the first of her Jamaican-born parents' children. She holds a Master's degree in education.

Lynne has extensive clinical and administrative management experience, in a variety of healthcare environments. She spent over fifteen years in progressive leadership roles, including five years as a discharge coordinator and five years as a service manager. In her current role as nursing director, Lynne is responsible for several patient care units and programs, and oversees a large staff compliment consisting of nurses and support staff.

In the position of nursing director, Lynne is responsible for program coordination, development and evaluation, and directs and participates in the preparation of departmental budgets, financial reports, and operational and/or capital budgets. She is also responsible for ensuring that the highest quality of patient care and services are maintained at all times. Lynne has had one interruption in her career for childbirth. She is very involved in several professional nursing associations.

Lynne relies on her Christian faith and beliefs to help her cope with experiences of racism and discrimination in the workplace. She spoke candidly and at length about her experiences. Interestingly, when she reviewed the interview transcript, she highlighted large portions that she asked to be excluded from the thesis for fear that she might be identified through certain experiences she related.

Nursing Executive Participant: Jeanette

Jeanette has held a number of senior nursing leadership positions in many healthcare organizations and settings, including executive director, and part-time faculty member at a university. She has spent over twenty years in nursing leadership roles at senior levels, and several years as a frontline nurse manager. During her career, she has played a major role in the nursing profession provincially, nationally and internationally.

Jeanette is a strong voice in health policy and health education here in Canada, and internationally. Because she has extensive leadership experience, she is directly involved in the activities of several professional associations and community-based organizations, including numerous not-for-profit boards. In her various leadership positions, Jeanette is responsible for ensuring consistent high quality care and service delivery, as well as effective management and professional practice.

Jeanette immigrated to Canada from the Caribbean; she is married and has a family. She holds a Master's degree in nursing and is currently completing a doctoral degree. She is a firm believer in hard work, and is dedicated to promoting excellence in nursing practice, but she is also aware that issues related to racial identity and discrimination create barriers and challenges for many Black and racialized women in nursing. In her case, she has been able to overcome the barriers and achieve professional success.

Jeanette actively participated in the interview, showing great confidence in her ability as a nurse leader as she openly communicated her perspectives and experiences.

Ethics of the Research

It is widely understood that care and due diligence must always be practiced to ensure the rights and confidentiality of the research participant is protected. Berg (2007) points out that "...researchers must ensure the rights, privacy, and welfare of people that form the focus of their studies" (p. 53), and that researchers "...have a professional obligation to honor assurances of confidentiality made to subjects" (p. 80). Similarly, Oka & Shaw (2000) emphasize that, "...confidentiality is a vital requirement for credible research" (p. 16). Therefore, ethical principles were upheld in every aspect of this research study.

First and foremost, participation in the study was voluntary. Secondly, the research study proposal was submitted to the University ethics review committee and approval was given to proceed. All the participants provided written informed consent before data were collected. (*Refer to Appendix C: Letter of Consent*). At the beginning of the research process, study participants were informed they were under no obligation and could withdraw at any time. None withdrew, and I assured them that their confidentiality would be protected.

Securing the Research Data

Confidentiality is an active attempt to remove from the research records any elements that might indicate the subjects' identities (Berg, 2007, p. 79). Berg (2007) also states that, "...anonymity means that the subjects remain nameless" (p. 79).

The utmost diligence was taken to maintain and protect the participants' privacy and personal information from unauthorized or accidental access or disclosure (Berg,

2007). Towards this end, all confidential information pertaining to the research — identities, summary notes, audiotape recordings and transcribed data — was secured to prevent unauthorized access. Additionally, e-mail was not used to send confidential information to the participants, and identifiable information was never disclosed by telephone or facsimile. To further ensure the anonymity of the study participants, a number and pseudonym was assigned to each participant and her employment institution, to ensure information could not be traced to either her or her employer.

Another strategy was to conduct individual interviews at locations selected by the participants to ensure their maximum privacy. As well, in the reports of the research findings, participant and healthcare facility identifiers are excluded from all the research documents, and are presented in ways that guarantee individual confidentiality and anonymity (Hassouneh-Phillips & Beckett, 2003). Healthcare facilities are not identified by specific names, but by general terms such as “the hospital” or “the health units.” Finally, the interview tapes and transcripts will be destroyed five years after the completion of the study.

Risks and Benefits of the Research

Despite the nature of the current research, there were no perceived risks or benefits for the study participants. However, because of the somewhat sensitive nature of the research questions, some study participants initially felt uncomfortable when asked to relate experiences of racism. For this reason, the interviews were conducted with the utmost respect for the participants’ feelings, and with awareness that painful emotions might be triggered. The participants were informed they could decline to answer any

question. A list of crisis counseling phone numbers was compiled and made available for the participants to access if necessary. To my knowledge, none of the participants required emotional counseling after the interviews. Understandably, several participants became tearful during their interviews while recounting their experiences in the workplace.

Data Analysis and Interpretation

One of the challenges of phenomenological research is analyzing the volumes of data collected through interviews, tape recordings and field notes (Harris, 2003; Van Manen, 1990). Berg (2007) contends that: “Qualitative data need to be reduced and transformed in order to make them more readily accessible, understandable, and to draw out various themes and patterns” (p. 47).

Van Manen (1990) suggests the notion of “themes and thematic descriptions of phenomena ... [is] helpful in generating deeper insights and understandings” (p. 100). Jaye (2002) claims that “qualitative research is explicitly interpretative” (p. 506), while Mittman (2001) cautions us that “Use of qualitative methods... is subject to wide variations and interviewer/observer bias and interpretation” (¶. 10). Mittman (2001) further mention that: “Steps to minimize these biases include...comprehensive plans of data collections, validation and storage, and frequent reviews of data quality and interpretation” (¶. 10).

Maxwell (1996) and others have suggested that researchers should take necessary steps to prevent researcher bias, such as including frequent reviews and repeat analyses of the research data, and getting respondents’ validation on the data and the conclusions

(Maxwell, 1996). These steps were taken in my research to ensure the reliability and credibility of my analysis, interpretation and conclusions.

Not long after the interviews were completed, I transcribed verbatim the audio taped data collected from the respondents in preparation for the analysis and interpretation (Maxwell, 1996). Each participant was sent their transcribed interview data to review for accuracy and completeness.

The “constant comparative method” of data analysis is described by Strauss and Corbin, as cited in Priest, Roberts and Woods (2002a), as “...an iterative process involving concurrently collecting and analyzing data with the...aim of generating a theory...that is ‘grounded’ in the natural context in which the inquiry takes place” (p. 31). Sixteen audio taped interviews, demographic questionnaires and extensive summary notes comprised the rich and extensive data collection that was analyzed using this method.

A qualitative research computer program, NVivo, was used to facilitate coding of the interview data from each of the participants, and to sort and manage the code (theme) files (Welsh, 2002). The NVivo program was selected over other data analysis software programs because it is relatively simple to use. Themes were organized into larger categories and subcategories in preparation for the qualitative content analysis (Priest et al, 2002b). Open coding, which is line-by-line scrutiny of the data to generate themes (Strauss, as cited in Urquhart, 2000), was used to examine the transcribed interviews and summary notes.

Qualitative content analysis “facilitates contextual meaning in text through the development of emergent themes” (Bryman, as cited in Priest et al, 2000a, p. 36).

According to Pope & Mays (1995), content analysis is the "...systemic examination of text...by identifying grouping themes and coding, classifying, and developing categories" (p. 42). After the preliminary thematic analysis, the individual narratives and perspectives of all the participants were analyzed for similarities and differences. All the participants in the study were sent a copy of their own transcript and asked to determine whether the analysis presented an accurate interpretation of their experiences. All responded to the request.

Summary

This chapter outlined the methodological steps taken to carry out the research, and described the qualitative research design and methods used, and the reasons for the selection of these methods. An overview of phenomenology was included.

The chapter also provided details on the characteristics of the sample, along with the techniques used for recruiting study participants, and explained the data collection process. The participants were introduced individually, and briefly profiled.

Ethical considerations and the risks and benefits of the research were discussed, and the process for securing data was explained. Finally, the chapter outlined the data analysis and interpretation processes.

In the next chapter, I will report the actual data findings.

CHAPTER FIVE

RESEARCH FINDINGS

Introduction

The main focus of this chapter is to present findings from the participants' responses to the four research questions that underpin the current study. As I had mentioned earlier, pseudonyms are used to protect the identity and confidentiality of each participant. Where appropriate, the participants' places of employment are referred to by pseudonyms as well, to ensure that no information can be used to identify an individual.

In some instances, and with the utmost care, the participants' verbatim responses to the research questions have been edited. In addition, editing of the interview transcripts of some participants was found to be necessary to eliminate repetition.

Each interview began with an open-ended question: Have you had any experiences in the workplace of perceived unjustifiable differential treatment and biases from your counterparts? Also, the participants were asked about others in the organization that treats Blacks differently. As the interview process progressed, each of the participants was asked more specific questions emphasizing the role of race in shaping their everyday experiences in the workplace environment as Black female nurse leaders. More specifically, each participant in the study was asked the following questions: Are any of the difficulties and challenges you face in your leadership role related to race or to other dimensions of identity? Do you think your experiences are different from women of other races in similar positions?

Other research questions related to the participants' feelings about their experiences of racism and other forms of discrimination, and the perceived impact on their work performance, are addressed later in this chapter.

In analyzing the data from the interviews and field notes, a number of themes/sub-themes emerged when participants answered questions related to their perceptions of differential treatment in the workplace arising from anti-Black racism. Themes that captured participants' experiences of racism and racial discrimination include:

Theme #1 - Perceptions of race-based differential treatment and biases

Sub-Themes

- 1.1 Perceptions of unwarranted and impermissible treatment by underlings, physicians, patients and their families
- 1.2 Perceptions of good to derogatory interactions with superiors
- 1.3 Perceptions of mistaken identity: Are you a real nurse?
- 1.4 Perceptions of unjustifiable performance scrutiny
- 1.5 Perceptions of dismissing and devaluing of professional opinions
- 1.6 Perception of condescending attitudes and behaviours

Theme #2 - Perceptions of flying by the seat of their pants

Theme #3 - Perceptions of invisibility and unimportance

Theme #4 - Perceptions of needing to prove themselves as leaders

Theme #5 - Perceptions of racial difference in career progress

Sub-Theme

5.1 Perceptions of racial identity as a benefit or a liability

Theme # 6 - Perceptions of the role of class and gender in participants' work experiences

This list is not meant to be exhaustive, but provides examples of key themes and sub-themes that emerged consistently from the nurse leaders' stories after coding and analysis of the interview transcripts. A number of them reflected similar thematic categories found in the reviewed research literature. For example, many of the participants' examples of perceived differential treatment are similar to those listed by the OHRC in a document titled: 'Policy and Guidelines on Racism and Racial Discrimination' (OHRC, 2005). In this document, the OHRC (2005, p. 29) states: The following types of treatment may be indicative of racial discrimination within the workplace environment:

- Exclusion from formal or informal networks;
- Denial of mentoring or developmental opportunities such as secondments, and training which was made available to others;
- Differential management practices such as excessive monitoring and documentation, or deviation from written policies or standard practices, when dealing with a racialized person;
- Disproportionate blame for an incident;
- Assignment to less desirable positions or job duties;
- Treating normal differences of opinion as confrontational or insubordinate when involved with racialized persons;

- Characterizing normal communication from racialized persons as rude or aggressive;
- Penalizing a racialized person for failing to get along with someone else (*e.g.* a co-worker or manager), when one of the reasons for the tension is the racially discriminatory attitude or behaviour of the co-worker or manager.

I have elected to report the findings under specific thematic categories.

Theme #1- Perceptions of Race-Based Differential Treatment and Biases

The women in the study were asked to discuss situations of differential treatment and bias that they perceived to be directed towards them. To further understand the context in which the participants experienced differential treatment and biases, I asked them to reflect on their experiences with co-workers, underlings, superiors, physicians and patients, and others of relevance.

Consistent with previously mentioned research studies on racialized nurses, nearly all the women in the study shared overwhelming experiences of being treated differently at sometime or other in their role as nurse leaders. A finding consistent with other research has shown that nurses from minority ethnic and racial groups perceive they encounter racially discriminatory behaviours from physicians, patients and patient family members (Turritin et al, 2002)

As the participants spoke of these experiences, the notion of subtle discrimination threaded throughout their responses. Of importance, very few participants (2) said they were not discriminated against or treated differentially at work because of their racial background.

Research consistently reaffirms that the differential treatment of Blacks in the workplace resulting from racial discrimination and biases, generally emerges in subtle ways. Margaret, a clinical coordinator who holds a Master's degree in nursing from the University of Toronto, said in the interview that although she had experienced negative differential treatment in the work environment, it was difficult to label her experience as racial discrimination. Margaret also mentioned that she have friends who label it very clearly that indeed it is racial discrimination. But for her it is a bit more difficult.

Margaret was uncomfortable discussing the topic; she was extremely guarded in her responses. She discussed her perception of her experience of differential treatment:

Margaret: It is subtle, and the circumstances are subject to alternative interpretations. There are also things that you don't know or you know after the fact. For example, when I decided to pursue additional higher education, I spoke to the medical and nursing management heads of my department. The medical director did not exactly discourage me, but he implied that I shouldn't go in this direction because of the cost involved, and that I would not be able to get the required funding. I reminded him that there was OSAP. In a flash of anger, I reminded him that parents across the province had difficulties assisting their offspring through post-secondary education, and that between educational initiatives and various grants and loan programs; it was possible to return to school. I guess I needed affirmation that it could be done, and that I would have his support. He was later instrumental in facilitating my continuing education, but at the time, his initial response saddened me. (17/5/05)

Margaret attributed being discouraged from pursuing higher education by a White male physician to her racial background, and voiced her opinion that his action could be a form of racism. In general, it has been suggested that there is acceptance of commonly held negative stereotypes about Blacks not wanting to pursue higher education. As well, she also expressed that her experience of differential treatment heightened her awareness of the saliency of race, and the strong possibility that racialization played a critical role in many of her experiences in the workplace. Furthermore, intentionally or not, the

perceived helplessness of the physician, in response to Margaret's retort to his racist comment, may be a shameful and guilty response in recognition of his racism.

It was noteworthy that the overwhelming majority of participants (14) voiced their perceptions that their current work environments and those of their White counterparts varied considerably in that Whites didn't feel their racial identity negatively affected their experiences. Moreover, most of the women emphasized that their experiences in the working environment were caused mainly by race-based discrimination and racist stereotypes linked to Black women. Some participants were quite emphatic about their racial background being the factor in them being treated differently than Anglo-Saxon nurse leaders. The participants said they reached their conclusions based on conversations with White colleagues, and perceptions of their own experiences compared with those of White nurse leaders.

Twelve of the sixteen participants perceived their workplace environments as 'unfriendly' towards nurses and nonprofessional workers from racialized backgrounds. As an example, Lucy, a nurse manager who has been in the role for the past two years, and who has worked in the same organization for close to twenty years in several informal leadership roles, perceived the atmosphere in her place of employment as 'poisoned'. In Lucy's words: "This is a 'poisoned' environment to be in on a daily basis, which forces me to pray daily before coming to work to be able to cope" (11/8/05). Lucy further noted that she turned to her faith to cope with the marginalization and inequity she encountered as a nurse leader.

The atmosphere in healthcare facilities can often be contradictory and bewildering. Intimidation and invalidation encroach on the work experiences of Black

female nursing managers, diminishing the quality of their work lives. And, it is very clear that the entrenched organizational mindsets constructed around racial and ethnic biases impact these nurse leaders and their opportunities for advancement.

Diane, another woman in the study mentioned that she is a committed Christian, and acknowledged throughout the interview that her faith and belief in God helped sustain her in the workplace; and environment she perceived as overwhelming because of racism. She is married with a family. Her husband and grown children are extremely supportive of her endeavours. Other women in the study also related that they relied on their faith and belief in God to sustain them in their work environments.

The following scenarios highlight several participants' perceptions. It is important to note that 13/16 participants perceived that the main reason for them being treated differently than their White counterparts was because of persistent racial discrimination and prejudice against Blacks in the wider, dominant society. Eleven of the participants perceived the differential treatment they experienced from White colleagues was a common occurrence in their work environment.

Heather, a nurse manager participant in the study with close to eight years experience in her role, reported that she was treated in negative ways when she initially became a nurse manager. Furthermore, although she has worked for several years in the same facility, and in the nurse manager's role for close to five years, she perceived that she was still treated differently than her White colleagues, albeit to a lesser degree. She discussed her perception about differential treatment:

Heather: When I first came into the role, I experienced [differential treatment] quite a bit where I felt that my experiences were different, and I still experience a bit of that today. That is in relationship to how some individuals respond to me, compared with how I see them interact with others, Caucasians. I

definitely see it in terms of individuals in administrative positions. For example, there are times when I make a suggestion and the response is not very favourable, it doesn't seem to be important. Someone else makes a similar suggestion, and I see how individuals would respond to that, it is more favourable. "Oh! You have made a good point...in a way that is effective." I definitely feel discomfort with that experience. (13/5/05)

Mary, who was contemplating leaving her job because of the level of stress in dealing with coworkers, voiced her perceptions concerning her experience with a White female colleague: "I was treated differently in the sense that there was no collaboration, no acknowledgement, actually passing by and maybe acknowledging one specific person and not me" (31/5/05). I asked Mary if she felt that her colleague treated her differently because of her race and ethnicity. She responded: "I think so only because I couldn't find any other reason or any history of conflict for me to say maybe it is something else" (31/5/05).

The vast majority of participants voiced their perceptions of having to work harder than their White counterparts to prove themselves to others, while receiving little in the way of acknowledgement for their efforts, and no credit for their productivity (when compared to their White peers). Margaret, one of the women said, "I have to give much more than Whites who get away with doing much less" (17/5/05).

These viewpoints are supported by Fernandez, as cited in Combs (2003), who states that, "...African American managers still perceive the requirement to be three times as competent as Whites to succeed" (p. 396). The Canadian experience mirrors this. Diana, another participant in the study said, "I am very conscious that I could be critiqued differently despite how good a job I do, that I would be evaluated on the fact that I am Black" (28/5/05).

Because of the prevalence of negative stereotypes and myths regarding Blacks, it is conceivable that they would alter their behaviours to avoid being evaluated negatively. In many ways, racialized minorities are likely to engage in behaviours they believe members of the dominant culture would perceive as appropriate, in an attempt to refute any misconceptions about them. However, it is noteworthy that, although a number of participants raised the issue of being motivated to work harder to avoid negative criticism, others said they were not influenced by the opinions of others. Regardless of their positional reactions or attitudes, none of the nurse managers changed how they performed their duties.

Five of the women perceived that they had to over-perform in order to be considered competent. As one of the women in the study said, "I have to give much more than some Whites who get away with doing much less." Notably, biases and prejudice towards racialized people make it difficult for them to establish authority and achieve success in the workplace hierarchy.

Mary, one of the participants with many years in leadership positions shared her perception of having to work much harder than her White colleagues.

Mary: I am expected to complete specific activities such as the monthly budget variance report for the unit that I manage on a specified date and there is little or no flexibility on the timeframe. Yet, I know of several White managers who either do not complete their budget variance report or submit it late and you never hear of any repercussion. (31/5/05)

Gloria, another participant also indicated that she felt the need to work harder to prove herself to her peers, physician coworkers and superiors. Consequently she has long working days. She stated:

Gloria: I am expected to be visible on the patient care unit to be a resource to the staff. I also attend patient care rounds with the charge nurse and physicians and

this generally takes up to two hours. I also maintain an open office approach so that the staff can come and discuss issues with me, and I have to attend to other administrative activities such as coordinating staffing schedules, completing written evaluations and conducting performance appraisals, attending committee meetings, budget planning, and identifying means of cost containment. I end up taking work home which constitutes hours for which I don't get paid. (9/7/05)

Mary, a nurse manager of a very busy unit in a large acute care facility had this to say:

Mary: These are minor little things that you think about after they occur. With the staff, I always felt that I had to do just that much more. In terms of ensuring that if anything was brought forward to me that it was always dealt with in a certain way, because there was more expectation of me being Black. It was never said, it was never articulated, but a lot of the time it was the way I felt. (31/5/05)

This is what some participants had *to* say regarding their day-to-day experiences of racism: "It is there, it is constant, and no escape, and who feels it knows it." The majority of participants (14) perceived that whenever they attempted to discuss discrimination issues with their White colleagues, their perceptions were generally trivialized or dismissed as unfounded. Heather, one of the participants in the study (a nurse manager) recalled she was told by a White colleague: "Oh please, stop imagining things. I don't believe that you are being treated differently" (13/5/05). When I asked her for a possible reason for the comment, she expressed her perception that most Whites choose to disavow racism as a reality in society because of the existence of systemic White privilege.

Martha, one of the nurse manager participants who work in a large acute care organization, shared her perception concerning experiences of racism on a daily basis within the workplace. She stated:

Martha: When I say daily, I don't mean Monday, Tuesday, Wednesday and Thursday. I am saying it is an awareness that is there; it is constant, whether it is a preconceived idea or my own interpretation of life, many things that other

people would not attribute to racism, I find myself attributing it to racism.
(30/6/05)

Lynne, a director of nursing who has over fifteen years of leadership experience in nursing, spoke at some length about an incident. Along with several other nursing leaders, she attended a meeting at a prominent hotel in downtown Toronto, and was perceived by another attendee to be a member of the hotel's housekeeping staff.

Lynne: When I got there, there were no chairs put out for this meeting. There were a couple of other women in the room at the time and one of them started putting out the chairs; in the meantime they had called the housekeeping staff. I left the room, and when I came back, all of a sudden this woman turned to me and in an angry tone said, "Why are you not putting out the chairs?" This was a meeting made up of many people from various organizations, and I was the only Black person in the room. She was talking to me as if I was one of the housekeeping staff, and here I am dressed up in my suit just like everyone else in the room, but she is talking to me and demanding that I put out the chairs as if I was the maid. As a Black person, every time these things happen, it takes you by surprise. I just walked away from her and at that moment the housekeeping people came in their house keeping gear. (3/7/05)

This extract taken from Lynne's interview reveals unwarranted and impermissible racism. Looking at the broader picture, based on Lynne's narrative, the literature suggests that the racialized body is consistently perceived as the marker of inferiority and lower social status compared to Whites (Dei et al, 2004). Indeed, although Lynne was dressed in a suit and carrying a brief case, her racialized identity and the class stereotype of Black women as domestic service workers overrode the seemingly obvious perception of her as a nurse leader. She described her experience:

Lynne: The value of me having a conversation with her about this in that forum, I could not expend the emotional energy to do that. Because every time you have to confront racism, you use up not only a lot of energy at the emotional level, you almost have to tap into your limbic system, into all that history of rejection and being treated as inferior, and deal with the rising anger and hurt and the pain. But to project myself at that moment to that person, not in an out of control manner because that is what they are wanting to see, but to engage them in a dialogue or in a conversation in which you can say what they have done and how it makes

you feel and what you want from them in the future, in that moment I was not prepared to have that kind of conversation with that woman. (3/7/05)

Lynne's decision not to address the issue and confront the person who mistook her for a member of the house staff could have been because addressing daily encounters of racial issues and insidious racist behaviours is a very difficult and stressful undertaking. It is also a possibility that Lynne chose not to address the issue for fear of being labeled confrontational and hostile, again based on stereotypical images of Black women.

Many racialized minorities do not want to deal with the emotional pain associated with the experience of racism. Hence, many of these individuals, as was the case in the study, may sometimes attribute experiences of racism to other factors that are less emotionally traumatizing. It is not unrealistic to assume that Black and other racialized minorities find it hard, in situations where they experience racist behaviours, to decide whether or not to confront these issues. They wrestle with the fears of being labeled a troublemaker, being ostracized by their coworkers or losing their jobs. Research conducted by Hagey et al (2001) found that racialized nurses in the Greater Toronto Area who complained of race-based discrimination and harassment in the healthcare workplace, faced reprisals such as job losses.

Several other women in the study perceived that they were not treated differently because of their racial background. However, as the interviews continued, a number of these participants went on to describe incidents that clearly pointed to differential treatment. Susan, a participant in a nurse manager position commented:

Susan: Hmmm, all my staff is White. Its fine, I do have their support. My former manager, (she is gone now), was very supportive. She provided support

for me to attend university at least one day a week as well as other days off when necessary. My present supervisor who is White is also very supportive. (3/5/05)

She went on to explain:

When we meet at the executive table, some of my peers don't think I have much to offer them. I usually laugh in my head. Some of my administrative skills and knowledge are not valued. I have 18 years of administrative experience and have been in several leadership positions at the executive level. I don't go around telling people that when I offer some suggestions. I do not flaunt my knowledge and experience so they don't think that I have anything to contribute in nursing administration. (3/5/05)

Pamela, another participant, is an acting nurse manager in a large teaching facility perceived she had not been treated differently because of her racial background and had not been discriminated against. Her response was:

Pamela: I'm quite new to the role of nurse manager. I've only been in this position just over one year. So, in response to your question, no, I have not had that experience. If anything, I must say that I have felt very much supported. I've felt very much supported. But given that...I'm the kind of person who is proactive...I don't wait for people. I will go to them and say, these are the issues, what are we doing about it? (14/10/05)

I asked Pamela whether she perceived differential treatment by her subordinates and, if so, was it perhaps due to her racial background. She remarked: "I have had that somewhat from subordinates" (14/10/05). Prompted to clarify her response and talk specifically about the subordinates whom she perceived treated her differently, she elaborated:

Pamela: I mostly find it's very, very, very subtle, and it's in respect to subordinates from my own culture, and I find that quite interesting. Outside my culture, I've had no issues, I've been supported and I've always felt respected, so there are no issues there. When there have been issues, even with people from my culture, I have dealt with them. I have brought people to the table, discussed what their issues are, and dealt with them. Given that I did not succumb to the disrespect, I think people have turned around and I have gained the respect because I have addressed the issues very professionally. I also find that it's like testing the water. I just take it that people are trying to test the waters to see how far they can go. (14/10/05)

Pamela was asked if she was referring to Blacks when she mentioned “people from her culture” (14/10/05). She confirmed that she was talking about Blacks in her previous comments. It could be suggested that Pamela’s disappointment at not being supported by Black underlings stemmed from the fact that, being one of the few Blacks to have achieved a leadership position, she expected other Blacks to be supportive of one of their own. Pamela perceived herself to be a role model and source of empowerment for others desiring to be in leadership positions. In her own words, “Here is one who has done it. Therefore, the opportunity is there and I can do the same thing too” (14/10/05). Pamela said she was quite surprised that not everybody thought that way.

Sub-Theme - Perceptions of Unwarranted and Impermissible Treatment by Underlings, Physicians, Patients, and their Families

The women in this study were asked: Do you perceive that your interactions with underlings, physicians, and patients and their families are influenced by your racial identity?

Although all the women in the study have advanced academic qualifications, and many of them have held a number of senior management positions in nursing, most of them perceived they were denied the same level of respect as their White counterparts. Specifically, they perceived their authority and professional status as nurse leaders was undermined by members of the healthcare teams, patients and patient family members.

As with the experiences of a number of the study participants, the literature suggests it is not uncommon for Blacks in leadership to have their authority questioned. This view is supported by Moses (as cited in Grimes, 2005) who states, “In some

instances, women of color who land positional power are often 'tokens' who have title but no real...power within the organization to make things happen" (p. 3). In this regard, due to the racialized nature of our society, Black women are positioned on the lower level of the power structure; consequently, their leadership is chronically undermined.

Most importantly, being in a position to give orders places one in a far different arena, where resistance from Whites who must take orders from a Black superior is not uncommon. Exclusionary practices -- based on race and/or ethnic biases -- from White colleagues and White senior personnel, go with the existing territory. Again, notions of racial superiority and inferiority reinforce unequal power relationships between White women and Black women.

Just under half of the participants (6) voiced that both White and racial minority subordinate staff openly and frequently questioned and challenged their decisions and actions. By contrast, one-quarter (4) perceived they had a good work experiences with both White and minority ethnic staff. There were also three who perceived that White, more so than Black subordinates challenged their authority. A small number of the participants (2) said 'their problem' was with subordinates from their own racial group.

Internal racism can also be multi-coloured. While such attitudes and behaviours on the part of some Whites (and to some degree non-whites) often present obstacles to Black nurse managers, the insidious nature of oppression is that it can also be transferred or imposed by marginalized 'others' unto other marginalized 'others'. As a result, Black nurses often experience differential treatment not only from Whites, but also from racialized subordinates, complicating the resolution of issues around which broad-based unity should be the rallying point.

The following interview transcripts illustrate some of the participants' perceptions about their experiences of differential treatment and biases with subordinates.

Gloria is another nurse manager participant, who has four years experience in the role and is in her second managerial position. She shared her story and perceptions of being treated differently by her subordinates in the workplace and felt it difficult to establish her authority and provide leadership because of race and class issues. Gloria's story demonstrates how biases and prejudice based on race make it difficult for her to establish her authority and provide leadership. She discussed her perception:

Gloria: Perhaps I was one of the first Black nurses to have entered that particular unit, and that created some difficulty for them. To begin with, they were resentful that a Black person was their manager. I was not received well; they wanted to go back to their former manager, who happens to be a White person; she allowed them to do whatever they wanted to. I am firm, yet fair. It was very difficult providing leadership to the group, and they tried to sabotage any initiatives that I attempted to implement to move the unit forward, taking into consideration the strategic directions that facility is headed. They just didn't want me there. I have experienced rejections and bad behaviours from a lot of people. I have had situations where some of the staff would try to manipulate and undermine what I was doing, or say the way they would do it...everything they did not agree with they would go to the union and take out a grievance. (9/7/05)

Lucy, one of the study participant said she enjoys her current positions as a nurse manager and teaching faculty member, but perceives that she faces challenges as a Black female in these positions. Lucy brought a lot of passion to the interview process; she talked openly about her perceptions of racism and differential treatment in the workplace.

Lucy shared her perceptions of differential treatment from her underlings.

Lucy: I have noticed in some of the places I have worked, where issues may have been addressed by a different manager, and if I address them, you find that the staff tends to take it as an affront. So they get more upset with the Black manager who deals with similar issues than they do with a White manager. (11/8/05)

Lucy's experience emphasized the dilemma many Black managers face in the work environment, when their management decisions are negatively assessed by staff. I asked Lucy if she perceived that the nurses' behaviours were because they did not respect her authority, or because of her racial background. In her words:

Lucy: I think the latter, simply because I have been a manager for a long time. I am very mindful how I speak to people, how I engage, and I think being Black and knowing that sometimes people tend to think of discrimination...I am always more cautious how I address people, not speaking disrespectfully. I may come across differently, but I am very careful about addressing issues. (11/8/05)

The job responsibilities of nurse leaders require them to interact with physicians. I asked the participants to describe their work experiences with physicians. Although the vast majority perceived that they had positive work experiences, there were a few who perceived otherwise. When I asked the participants if gender or race influenced their work experiences with physicians, almost half of the women (7) reported their perceptions that gender was more a factor in determining the relationship than race.

Examples of participants' comments regarding their work experiences with physicians:

Martha: My interactions with some of the physicians lead me to think that race is somehow an issue with them. It is the way that they respond to you... and a lot of the time it is subtle; it is hard to say that it is discrimination. But it is the way that you see them interacting with a White manager compared to yourself. It is the difference that they pay to them [Whites], and the fact that they listen and recognize what that person is saying, very different to you [a Black manager] even when you are saying the same thing. For staff, I have found that at times, that they don't want to work in a situation where they are reporting to a Black manager. On the other hand, non-white staff wants to work in a situation where they have a manager that they think will understand them more so, and not prejudge them. And that they will not be judged by race alone. (30/6/05)

Lucy, a nurse manager with less than two years experience as a manager at a large university-affiliated hospital, described an incident that involved a physician on her unit:

“I have experienced inappropriate treatment from physicians. For example, one White female physician was standing in the nursing station, and I said good morning to her and she just kept reading” (11/8/05). When I suggested that the physician might not have heard her, she adamantly stated:

Lucy: Yes she did. The nurses at the nursing station turned around and looked at her, and I went up to her and said good morning. She still didn't answer me. So I called her by name, and I said that I said good morning. And I left. (11/8/05)

Lucy was asked if she felt this situation could have happened to anyone regardless of their racial background, and she replied: “I don't think so. I have watched her behavior with White people, and she behaves differently” (11/8/05)

Alison, who holds a senior leadership position, recalled an incident involving a physician when she was an interim director. In her narrative, she described her experience:

Alison: There was one physician who needed something done in his clinic, and he wanted it done immediately. We met, talked about it and he did not get the answer that he wanted. So he decided he was going to my superior to get the answer, even though it was a clinical decision. I felt that I had jurisdiction over those kinds of decisions. (3/6/05)

Alison was asked if she perceived that her race influenced how the physician responded to her decision, and she replied:

Alison: It may have, but I cannot say definitively. But I do know it was deferred to my boss who is a White male. But he (the physician) was sent back to me because it was a decision that I needed to make. Whether or not I was a Black female or regardless of class, there is a very clear mandate and support for the role. But regardless of all of that, people need to understand that certain behaviours are unacceptable. (3/6/05)

Mary, another participant in the study, initially reported that gender and professional hierarchical differences between physicians and nurses were factors that determined the quality of nurse/physician working experiences. But when asked again if

she perceived that race played a role in her interactions with physicians, she stated:

“Yes...so race can add another dimension” (31/5/05). I sensed that, perhaps because of her previously stated comment that discounted race as a factor, there was some equivocation in her answer.

Mary: Yes. For physicians, I don't know if it has to do with the culture of the organization. Whether you are White or Black, there tends to be that feeling there is a hierarchy. I don't think it has to do with race. I would argue gender difference and professional status, more so than race. (31/5/05)

Heather: In terms of physicians, over time, I have gotten to know a lot of the physicians quite well, and so negativity is not necessarily my experience. (2/6/05)

Christine: I have been fairly fortunate; if that happened, it must have been so subtle that I didn't recognize it. Nothing blatant. (3/9/05)

Sub-Theme - Perceptions of Good to Derogatory Interactions with Superiors

Some of the participants' narratives revealed that they found it difficult to confront a White person with authority about their racist behaviours for fear of the person being angered or upset. Indeed, challenging daily experiences of racism is a daunting task, and is not without risk for the racialized person. Participants made it clear that most Black nurses in leadership positions felt extremely vulnerable in their workplace environments because their status as non-unionized employees, combined with their racial identity, amplified their powerlessness and levels of stress. Job security is not guaranteed for most non-unionized employees, especially those perceived as 'troublemakers', because they have broken the silence on issues regarding racism and other forms of discriminatory practices.

Racist behaviours may not be questioned due to concerns about being considered an insubordinate and being reprimanded. In short, the hierarchical and power differentials between a Black nurse leader and a White superior play a key role in these situations.

Although many participants (13) commented that they had good working experiences with their immediate superior and felt supported in their role, a few (3) expressed feelings of lack of support, as well as being treated differently by their superiors. Diane talked about her experiences as a nurse manager in four different settings over twenty years. At the beginning, when describing her first experiences as a manager, she was hesitant. Eventually she admitted that it was difficult for her to know what really happened to her during that time, but the ambiguous nature of her comments intimated that she might have been treated differently to the White managers. Her narrative described her situation:

Diane: I cannot say that the White managers were treated different from me because I was the only Black manager. I felt that it may be that I needed more education and more understanding of the role. For example, a former superior told me that I was the cause for an enquiry on a patient who died shortly after I was hired. (28/5/05)

I suggested to Diane that she might have been expected to participate in the inquiry because she was the manager. She replied: "I felt that other nursing leaders should have been involved in the inquiry because I was relatively new to the facility" (28/5/05).

Diane indicated that her superior, a Caucasian woman, kept telling her during this time that she was stupid. When Diane was asked to describe her feelings about the negative comments, she said, "I felt belittled, and questioned if I had the skills to be a manager" (28/5/05). Diane maintained she was unable to determine whether or not she

was treated differently, because she was the only Black manager working in her organization and unable to make a comparison.

Margaret, a clinical coordinator who reports to two superiors, a nurse and a physician, described her experiences with both: “In my case, the fact that I am a woman, a woman of colour, and a nurse perceived to be subordinate to a physician, colours my perception of my relationship with the person/s I report to” (17/5/05). When I asked if she perceived being treated differently to her White colleagues, Margaret could not give a definitive yes or no answer, saying it was difficult for her to attribute any offensive behavior toward her to being treated differently because of her race. I then asked her if this might be an easier way for her to deal with the situation, to which she replied: “Yes, that is always a possibility. I may not necessarily want a confrontation, to feel that I need to label an experience or to stir up things that I won't be prepared or comfortable to pursue” (17/5/05).

When asked to describe how she deals with these issues, Margaret said: “I have dealt with them in various ways, but I am usually accused of being overly sensitive and advised to grow a tough skin” (17/5/05). Upon being asked to elaborate on her feelings about being told by a White person that she was too sensitive and needed a tough skin, she said: “Other times, frankly, I am disgusted and sometimes feel helpless to try and change the person's behaviour” (17/5/05). As to whether she attributes the person's comment to racism, she remarked:

Margaret: I sometimes attribute behaviors to racism when I cannot rationalize why they're happening, and when they occur frequently, and without visible reason, to an ethnic person. As an example, we had a difficult time recruiting clerical support staff and eventually hired two minority secretarial staff. At the time, my superior was indifferent to one of them; the second person he expressed dissatisfaction with, accused her of being lazy and commented that her work

standard was not comparable to the other secretary. They were both minorities, different races, but there seemed to be a fixation on one of them and I would often be questioned as to why she could not be fired. I had never seen or heard of anything quite like it, and even though the position was not unionized, I could not justify dismissing the secretary. This criticism began within weeks of her being hired. I couldn't help but wonder that the behaviour was racially motivated. This was not about performance; even when their performances were compared in an objective report, the accusations and demands persisted until I demanded that the complaints be made formal and in writing so that others would have to become involved in determining an appropriate response. Coincidentally, this particular clerical staff member that was targeted spoke out very strongly against any perceived slight or disrespect toward her, and I actually admired her for this as she took on challenges that I didn't always have the nerve to confront. (17/5/05)

This excerpt from Margaret's narrative illustrates how a stereotypical racist ideology of Black women was perpetuated in the behavior towards the two minority secretarial staff in Margaret's narrative. It is noteworthy that Margaret expressed admiration for the racialized staff member who confronted the racist behaviour from a White superior. When Margaret was asked why she had not had the nerve to confront the issue, she answered:

Margaret: Because the particular instance that I am thinking of was a common occurrence between physicians and non-medical staff. In one instance, a doctor actually threw a file on the desk toward the secretary. In doing so, the file hit the secretary, and she commented on the inappropriateness of the doctor's action. The doctor retorted something derogatory such as, "I don't know why you are here, you cannot follow instructions." This secretary could be my mother and I had a lot of respect for her, and she actually came to me and said that she was going to wait until the clinic had ended and would speak with the doctor about the behaviour. She also noted that she would not be disrespected or be treated in the way that she had been. After this transpired, although the doctor was cool towards her, the behaviour improved. I have never seen anything like that. It is not that I disagreed with how she dealt with it, but I had not been strong enough to approach the problem in the past. It is still quite difficult to communicate that a certain behaviour or action hurts our feelings, and even more difficult to summon the indignation that would prompt a demand for a change in behaviour we find offensive and racially motivated. (17/5/05)

Sub-Theme - Perceptions of Mistaken Identity: Are you a Real Nurse?

Over half of the study participants (10) shared experiences of differential treatment that occurred during contacts with patients and families, although in many cases they indicated that it was difficult for them to determine whether this treatment was related to their racial identity. Their perceptions of these interactions varied: five participants said they were seldom acknowledged as the manager of their respective units; 3 reported they felt disrespected and had been on the receiving end of condescending treatment and disparaging comments; and 2 reported being mistaken for a bedside nurse or a member of the housekeeping staff.

Martha, who in her role as a nurse manager provides leadership to a large staff, said that she has been mistaken for a clerk or social worker because she is not dressed in the typical nursing attire. In her words:

Martha: I have walked into a patient room and because I am not dressed in a nurses' uniform, patients and their family members tend to think I am the clerk or social worker, or somebody else. When I have introduced myself as the manager, they typically appear bewildered and say "oh...I thought someone else was the manager. (30/6/05)

Pamela, another participant recalled an incident when she walked into a patient's room, and was asked whether she "...was a real nurse or one of those pretenders" (14/10/05)? She noted that when she responded, "I am not sure what you mean," the patient said, "Are you one of those nurses that went to school and got a nursing license" (14/10/05). When she replied that she was a qualified nurse, he apparently stated, "You look too young to be a nurse" (14/10/05). The participant surmised that the patient saw a Black woman, and could not believe that she was a nurse, but perhaps thought that she was a cleaner.

A somewhat similar incident was described by Heather, who provides leadership and direction to a large nursing and support staff. She felt that a patient's wife treated her disrespectfully by referring to her as "a lovely little girl," failing to recognize that she was a professional woman.

Heather: Oh, I have this lovely little girl here." I finished what I was doing, and I asked to speak to her outside. I told her I am not a little girl, and that my name is Heather. She said, "Oh I am sorry, I guess I should call you an old lady then." So I said I am not a little girl or an old lady. My name is Heather, and I am a nurse. (13/5/05).

Lynne described her experience of racist stereotyping, where seeing a Black woman in a nurse manager role created surprise and even astonishment from a number of White patients. Lynne described one of her experiences as surreal, as she entered the patient's room to follow up on a complaint regarding a frontline nurse.

Lynne: So who are you? I started off by saying I am the nursing unit manager, she never heard that. She asked me five minutes later who I was, and I told her, and five minutes later the conversation changed. No eye contact. And I found her very dismissive, so I just treated her as a patient. (13/8/05)

Other participants' experiences were more positive, and they noted they were treated respectfully as nurse leaders by patients and families. Linda, one of the nurse managers' stated, "I hear from my boss that patients and their families really love me and that I am doing an excellent job" (13/7/05).

Susan was another nurse leader who said that she did not perceive being treated differentially to Whites, and that the patients and their families seemed to accept her as a nurse manager without any colour-related issues. "I don't walk around thinking about colour unless something happens and I have to stop and think what that was all about" (3/5/05).

Echoing the point made by Mary, Diane another participant who has worked as a nurse manager in four different healthcare organizations stated that in all her practice she has never come across patients who had issues with her being a Black nurse manager. Yet, upon further reflection, she did recall an incident that occurred when she was a department manager, and a patient requiring a set of crutches was sent by the technician to see her.

Diane: I asked how I could assist him, and the person kept on saying, can I please speak to the manager? And I kept saying, how I could be of help to you, hoping the person would connect and see that I was the manager. This went on for a while until eventually I lifted up my name badge and showed him that I was the manager, and then he calmed down. (28/5/05)

Sub-Theme - Perceptions of Unjustifiable Performance Scrutiny

One prominent perception that emerged from the interviews was that of excessive scrutiny of the participants' job performance and leadership, and the fallout thereof. This finding is consistent with other research regarding racialized groups in the workplace. It is not uncommon for members of these groups to continually have to prove their competence. An additional dilemma these women face is that, while on the one hand their leadership is often undermined, on the other they are burdened with higher expectations and held to higher standards of performance than their White counterparts.

hooks (2001) points out that because of racist beliefs and practices in many organizational structures, Blacks are often the recipients of harsher criticism about their job performance compared to Whites. It is further suggested that repeated criticism and negative stereotypes produce less positive attitudes towards Blacks, making it difficult for them to be successful. This, in part, explains why Black women are likely to have less

self-confidence in their ability to function in certain roles (Thompson & Skaquaptewa, 2002). In reality, the difficulties Blacks encounter in the work environment are usually because of racism, as opposed to their inability to fulfill the requirements and functions of their position. Generally, the women perceived they constantly had to prove themselves, and 'not drop the ball'.

In this study, the responses from several of the participants reveal a world where they are made to feel that whatever they do is never good enough, even when their efforts and contributions are equal to, or better than their White co-workers. Many of these women said they continually had to prove their competence. Some were energized by their day-to-day experience of racism. Others found the experience to be emotionally and physically draining.

Attitudes such as those identified are not uncommon from patients and family members. But within the collegial environment of a healthcare institution, blatant pernicious remarks from coworkers are not the norm. However...attempts at devaluation are. This is witnessed in the unwarranted scrutiny of many of the participants' job performances, indicating unspoken doubts about their competence, and a perceived need to monitor them more closely than White female nurse managers. The literature suggests that racism violates individual's perceptions of their ability, attitude and performance.

The major problem is that job competency in contemporary society is based on Eurocentric standards, and generally defined differently for racialized groups. For this reason, individuals from racialized groups are often uncertain regarding defined expectations (which may be -- perhaps deliberately -- unclear). The result is often unmet expectations and, consequently, racialized individuals being assessed as incompetent.

Reality for the Black nurse leader might well be predestined by an institutionally applied aegis factor, a conscious effort at managing Black women's aspirations while protecting White power and hegemony in the workplace. The effect is to keep Black women off balance, and to inhibit them scaling the hierarchical ladder.

What was also confirmed by participants was that their leadership was often invalidated by White colleagues, and that biases and prejudice based on race made it difficult for them to establish or assert their authority as nurse leaders. This is borne out by Petrie & Roman (2004) who argue, "A lack of autonomy in one's work environment is a means of disempowerment and reflects, as well as reproduces, labor market inequalities" (p. 591). There is no doubt that the "disempowerment" spoken of by Petrie and Roman is a very real factor in the experiences of the women in this study, and unquestionably has contributed to a diminishment of job satisfaction.

As Linda, another participant said in reference to an incident involving a White colleague, "I was really angry because I thought that she had just undermined me. I am a good manager, and being a good manager has nothing to do with my skin colour, and I was doing my job" (13/7/05).

Alison, one of the participants in a senior level nursing position, mentioned that when she was in a manager's position, her decisions and actions were frequently scrutinized by subordinate staff:

Alison: With the staff, I always felt that I had to do just that much more in terms of ensuring that if anything was brought forward to me, that it was always dealt with in a certain way, because there was more expectation of me, being Black. It was never said, it was never articulated, but a lot of the time it was the way I felt. (3/6/05)

Alison was asked what was happening that caused her to feel the way she does. She replied that, "There was always a comparison between myself and the previous manager, who is White. They would say so-and-so would have done it this way" (3/6/05).

Gwen, another nurse manager participant with many years of experience in leadership, voiced that she was very conscious that she was critiqued differently to her White counterparts no matter how good she was at her job. She also addressed the issue of being tested in her position because she is Black. Her response was:

Gwen: I give someone an assignment, and somehow they think testing should be done. It may be that I am new at this role, but it also could be because I am a Black woman. I don't let a lot of things bother me because I make it very clear that if there is something that needs to be done, it has to be done. (9/7/05)

Lynne, a participant who has extensive clinical and administrative management experience, perceived being ignored by a particular physician on a number of occasions. However, she felt that in her case he was testing her competency, and she had to prove her ability as a manager.

Lynne: There was a physician who, when I first went to the last hospital, basically just ignored me. But he tended to ignore everybody until he got to know them. But in my case, I think he was testing to see whether I was competent in what I was doing before he could work with me and respect me. After awhile, he was OK. But I never had a relationship with him where I felt totally comfortable. (3/7/05)

Lynne's experience is a common perception among Blacks in that their competency and abilities are questioned and scrutinized.

It is evident from several of the participants' narratives that they encountered excessive scrutiny of their job performances from immediate superiors, coworkers, subordinates and physicians. Just over half of the women (9) claimed there was 'no room

for error' for Black managers. Mary, one of the women in the study stated that she could not "mess-up" (31/5/05); have a lapse in judgment or make an error, otherwise her job performance would be criticized and her competency brought into question. This clearly conveys the level of stress, inculcated by the need to continuously look over their shoulder and second-guess themselves that taints the working experiences and lives of these women.

It should come as no surprise that some participants reported that their self-confidence was negatively affected by unreasonable expectations, excessive scrutiny and criticism. In addition, many participants said they were cautious exercising their authority for fear of being challenged or judged negatively. They reported that, under these circumstances, they themselves have fallen into the trap of questioning their own ability to fulfill the requirements of their leadership roles. As Diane stated, "it makes you feel like you are not good enough and it makes you question if you are able to do the job, are doing it correctly, are doing the right thing, and are competent" (28/5/05).

This continual self-questioning leads to a loss of confidence, a 'second guessing' of decisions and the 'bated-breath syndrome' typified by the anticipation of criticism or censure. This is evident in Mary's comment that, "Because you are not as sure of yourself, some things that you should be dealing with you may step back and not deal with it. There is a fear of failure because you think that as a Black person you have to do it right" (31/5/05).

Almost half of the participants (7) expressed apprehension about making decisions because they anticipated negative consequences. In general, the fear of being evaluated negatively caused some participants to seek the support of human resources

staff prior to making decisions related to staff issues. This fear of a negative evaluation was obvious when Mary commented, “You are always cautious, always trying to avoid the accusations, causing you to reflect more, be slower to act. It really tests your confidence” (31/5/05). This confidence was further tested when the participants had to deal with staff-related issues, because they didn’t want to be accused by Whites of giving preferential treatment to racialized staff or, on the other hand, be accused by Blacks of favoring Whites. Three quarters of the participants (12) said they were caught between a rock and a hard place. In other words, darned if they do, and darned if they don’t.

Sub-Theme - Perceptions of Dismissing and Devaluing of Professional Opinions

The literature suggests that the limited number of Blacks who have ascended to management roles often find that they do not have autonomy equal to that of their White counterparts. It further suggests that their opinions and input are typically not solicited and, when given, are often overlooked.

The nurse leaders’ experiences are related to several factors: the racist portrayals of Black women over the years that have supported the idea that they are unable to engage in any meaningful discourse; the phenomenon of racism that consistently supports a belief that Black women should be seen but not heard; and the insidious assumption that Black women’s skills, knowledge and experience have no value.

In many of the participants’ comments, we see a general thread of how their opinions were repeatedly ignored or criticized and deemed irrelevant, by their White co-workers and supervisors. To add insult to injury, on the rare occasions when the Black nurse leaders did have the attention of the room, a White colleague would often consider

it necessary to interrupt and take over, to 'clarify' the comment. But only if the content of the comment was in agreement with White opinion.

These women also reported that the opinions of their White peers were positively received in public forums and management meetings. There can be little doubt that a pervasive climate of superiority developed among these nurse leaders' White colleagues. Consciously or not, they relegated the comments and observations of the Black female nurse managers to the margins, even as they advanced their own suggestions and opinions, and consequently found their contributions to be valued.

Consistent with previous studies on racialized managers, a number of the participants said that their ideas and professional opinions were frequently ignored or not taken seriously by their White colleagues and supervisors, and they were not credited for their contributions. Lynne, a senior nursing leader noted, "My administrative skills and knowledge are not valued. I have over fifteen years of administrative experience, and have been in several leadership positions at the executive level" (3/7/05).

Some participants perceived this dismissive treatment of Black women as a silencing strategy to prevent them from making contributions. As an example, Gwen, one of the nurse managers stated, "The opinions and ideas of my White colleagues are not dissimilar to mine, yet my opinions and those of other Black colleagues are looked upon negatively" (11/5/05). She added, "That is one of the main reasons I will not give my opinions publicly" (11/5/05).

Heather, a nurse manager, had this say: "I am in a meeting and made a suggestion that is not picked upon, but someone else says it, like a White colleague says it, and oh, it is the most brilliant thing ever said" (2/6/05). The following comment from Christine,

who has been in a nursing leadership position for close to fifteen years, further illustrates the lack of regard for Black nurse managers' professional and personal opinions and ideas:

Christine: When you share your ideas at the table, even a blind man would notice that your ideas and opinions are not taken up and not acted on, and it is almost as if you didn't speak. On the other hand, the ideas and suggestions made by Whites will be supported and accepted as a revelation from heaven. I truly believe that race has something to do with this type of situation. (3/9/05)

Mary, another participant from the same facility, claimed that when Black managers offered their opinions, it was a common practice among her White coworkers to interrupt and attempt to clarify the Black managers' comments, as if they (the Black managers) were unable to communicate intelligibly. She also said that it is a commonly held belief among Whites that racial minorities -- Blacks in particular -- lack the intellectual and linguistic capacity to express themselves clearly. Having White colleagues 'translate' their comments is a subtle form of racism that is extremely painful for racialized speakers.

Linda, another participant, at the start of the interview emphasized she had never perceived being treated differently to her White counterparts. She became emotional during the interview as she voiced concerns that her communication and language abilities were evaluated negatively by her superior. As well, she was extremely sad and tearful as she recalled her experiences of having her comments translated by White coworkers. After taking some time to compose herself, she indicated that it was still very painful, that she had not fully resolved her feelings about the feedback she had received and that she was contemplating bringing up the issue with her superior. She stated:

Linda: I have had a recent experience, however, and it has made me wonder. It tied into a performance appraisal which I recently had, and which was a very

good appraisal. One of the ratings was lower than I expected, in communication, and I feel that I was dealt with unfairly. I strongly believe that I am a very good communicator, both written and verbal...I tried to explain to the team all the processes the nurse undertakes, and how they come about their final decision. I went into a lot of detail, and it wasn't appreciated...I wondered whether it is my ethnic style of using words, or I am wordy. I am really struggling with it.
(13/7/05)

It could be argued that Linda's story illustrates a commonplace belief of Whites that racialized minorities lack effective communication skills. It is reasonable to argue that verbal communication skills in Western contemporary societies are measured against Eurocentric standards. In this context, it could also be argued that Whites tend to think that those non-Whites (and even some Whites, particularly Eastern Europeans) who speak English with a foreign accent are unintelligible, illiterate or incompetent.

It is clear in the literature that many racialized minorities for whom English is not their primary language, or who alternatively speak English with an accent, have to frequently contend with flagrant criticism of their verbal communication skills. This attitude toward non-White English speakers, many of whom (in relation to this study) are immigrants to Canada from former British colonies, is directly tied to colonialism and British imperialism.

English was introduced in the British colonies as a "...vital appendage of British colonial rule, one that was to be used as an instrument of oppression, alienation and marginalization of the indigenous peoples" (Dissanayake, as cited by Amin, 2005, p. 186). Thus, in the context of the experiences of Black female nurse managers, there is an automatic assumption that these women cannot articulate 'proper' English and, as such, their comments need to be 'interpreted' by Anglo (White) speakers, this 'interpretation' serving as an instrument to both marginalize and oppress.

Another instrument, as pointed out by Lucy, is White people rolling their eyes in reaction to suggestions. The OHRC (2005) provided the following example that underscores the participant's observation: "A manager frequently rolls his eyes or interrupts when a racialized employee speaks during staff meetings, even though nothing untoward is being said. The manager is not observed to do this with other employees" (p. 27).

Lucy, remarked: "I went to my director and pointed out to her [that] when your answer is not in keeping with their [Whites] ways of thinking, it is disregarded, belittled or just totally ignored" (11/8/05). Lucy was asked to describe her director's response. She recalled that her boss said she should address the issue herself at the time the incident occurred. From Lucy's perspective, the director's response is a position frequently taken by Whites who are reluctant to confront or challenge others about racist behaviours, for fear of being perceived as taking the side of a racialized person. Therefore, the burden of addressing racist behaviours is frequently left to members of racialized groups.

Many of these women generally felt out of the loop, which in turn they perceived affected their decision-making ability and their leadership. As a result, many participants felt/feel it necessary to create professional space and opportunities to speak and be heard as they struggle, in varying degrees, to establish themselves in their roles and assume their rightful positions as leaders.

Sub-Theme - Perceptions of Condescending Attitudes and Behaviours

Another participant, Diane, said during the interview that it was her passion and commitment to the profession that enabled her to look beyond experiences of racism in

the workplace and the profession. At the start of the interview, she was rather quiet and spoke reluctantly about her experiences. It took a great deal of encouragement for her to open up and share her perspectives. It was obvious that recounting her experiences in the workplace was very painful. Dianne recounts one such experience:

Dianne: A nursing director told me that I did not speak clearly, and another said that I wore my hair very messy. I wore very short hair and in an 'Afro' style and it was also combed or brushed through. Because she was White with long straight hair, she thought that my hair was very untidy. I guess that I don't meet the Eurocentric standard of grooming. (28/5/05)

Diane was asked if she perceived the director's comments were based on racial stereotypes of Black women to which she replied: "Yes, and It was every little thing, the way I dressed, spoke and carried myself" (28/5/05).

Alison, who has close to eight years of nursing leadership experience, recalled an incident involving a patient who made negative comments about her to the staff, noting that the attitude of this patient's family member definitely reflected racism, and was one she would never forget. She reported that the person said: "Why did that Black bitch think she could make all the decisions, and who does she think she is" (3/6/05)? She explained that this inflammatory comment came back to her verbatim from the staff, and described how she dealt with the situation. When asked how she thought others perceived her as a Black female nursing director, Alison stated: "Truthfully, I don't think about it on a daily basis. I say that honestly because I am here to do a job and I don't spend a lot of time worrying about what people think about my colour" (3/6/05).

Pamela is another nurse leader who relayed that some White patients seemed surprised and taken aback when she introduced herself as the nurse manager on her morning rounds. She further mentioned: "Usually with visitors or relatives, younger

relatives, they have a certain amount of bewilderment because they're always looking for somebody else. My thinking is maybe they are looking for a White manager, because a White person is always the leader" (14/10/05).

Margaret, who handles the diverse functions of a clinical coordinator, commented regarding an incident involving a patient who referred to her as a "monkey." Margaret expressly stated: "...using an extremely derogatory word to degrade another human is unacceptable and racist" (17/5/05). Margaret was asked what her feelings were regarding the derogatory comment. In her words: "It bothered me because this is someone who knew who I was, and also knew that I was the only nurse of colour in the clinic" (17/5/05). She stated she didn't feel comfortable pursuing any action against this patient. She shook her head saying, "Sadly, hospital administrators would not support such a claim against a patient, especially if it is made by a Black nurse" (17/5/05).

Jeanette, another participant who has held a number of senior nursing leadership positions in many health care organizations and settings, recalled the following incident:

Jeanette: I was in a senior administrator position and two men had an appointment with the senior administrator which was me. When they entered the building and said, "Hello I'm here to see the executive administrator," my White assistant called me. It was amazing when I walked towards the two individuals; one of them reacted to seeing a Black woman was the senior administrator. I said, hi, I'm Jeanette and how may I help you? He replied, "We're just calling to say hi, nice meeting you." But the other one was so taken aback, and he said, "You must have been very, very lucky to get this job." I simply replied "I'm Jeanette, good morning, welcome." So I didn't respond to him then because I had planned when I got into my office I would talk with him. When I got into my office, I said, "In response to your statement, I was the most qualified out of ten people to have secured this position. I got the job on my ability and not on anything else." And I went as far as saying I was the only Black candidate out of the rest of them and the other candidates were White. (13/8/05)

Another participant, Lucy, reflected that many Whites continually interject when she is speaking to explain and clarify what she has said. She said of her experience:

Lucy: Sometimes in open forums it seems that some managers get more attention for their comments. Although they are polite and ask your opinion — I am talking about senior management or the co-chairs of these groups — someone is always willing to explain what it is you mean. (11/8/05)

When asked whom she meant, her reply was:

Lucy: Another of my White peers, and that is only when it is in keeping with their thoughts. If it is contrary to their thoughts or philosophy, their objection comes through in their responses. They don't have to use words; you can see their body language, eyes rolling etc. (11/8/05).

Theme #2 - Perceptions of Flying by the Seat of their Pants

The reviewed literature suggests that individuals who receive appropriate mentoring demonstrate better job performance, as well as increased job satisfaction and retention, than non-mentored individuals. (Eby et al, 2000). As Tappen (1989) suggests, an effective mentoring relationship in the workplace nurtures a sense of belonging and worth, provides access to resources and collegial networks, and is vital to an individual's success.

The role of mentorship is crucial for both neophyte and experienced nurse leaders (Porter-O'Grady, as cited in Hay 2004). Mentorship is a "dynamic and non-competitive nurturing process...that promotes independence, autonomy, and self-actualization in the protégé while fostering a sense of pride and fulfillment, support, and continuity in the mentor" (Valadez & Lund, as cited in Kilcher & Sketris, 2003, p. 3). Chao, Walz, and Gardner, as cited in Kilcher and Sketris, 2003, p. 3, define mentorship "as an intense

work relationship between senior (mentor) and junior (protégé) organizational members. The mentor has experience and power in the organization and personally advises, counsels, coaches and promotes career development of the protégé.”

On the other hand, feelings of isolation are not uncommon when positive mentoring and networking opportunities are not available. Because of societal biases, and the racist and hegemonic practices that are imbedded in institutional structures, it is reasonable to suggest there may be substantive differences in the support and mentorship available to workers of different races. Another important point is that ethno-racial minorities consequently experience difficulties in the workplace because of insufficient mentorship and limited networking opportunities with members of the dominant culture (Queralt, as cited in Chima and Wharton 1999).

To gain an understanding of the mentoring and support available to the participants in this study, they were asked the following questions: (1) Have you received support or mentoring for your professional development as nurse leader? (2) Were you assigned a formal mentor when you started in the manager’s role? (3) Do you feel that you got the same amount and type of mentoring as White managers? The participants’ responses covered both formal and informal types of mentoring during their leadership development. Several of the participants categorized this assistance as acceptable and equal to that received by their White counterparts. As an example, Heather, the youngest of the nurse managers in the study, reported: “I don’t feel I am treated differently from Whites in terms of being mentored” (2/6/05).

In the context of the current research study, many of the participants indicated that they did not receive the same levels of administrative support and mentorship as their White peers did from their immediate supervisors.

This finding concurs with the results from a study by Simon, Bowles, King and Roff (2004) that looked at the role of mentoring in the careers of African American women in the administration of social work education. The authors reported that adequate mentoring opportunities were not readily available to these women; nonetheless, they “were successful in their careers” (p. 134).

Additionally, the authors suggested that, “race and gender play important roles in the types of mentoring experienced by African American women in social work academia” (p. 134). Similarly, Sanchez-Hucles (1997) point out that Black women rarely have the luxury of benefiting from support and assistance from work colleagues. Also, Ibarra, as cited in Lovelace & Rosen (1996) noted that “Minorities have fewer same-race role models, mentors, or sponsors within their organizations” (p. 703).

The convergence of the findings by the aforementioned authors is repeated in the experiences of many participants in the current study. Despite the fact that the women reported being denied the adequate support and mentorship they were entitled to, they had been able to achieve success in their roles as nurse leaders, albeit at great cost to their emotional health and wellbeing.

It must be noted that the experiences of the women in this study across an issue such as mentoring were not homogeneous. Some had positive experiences with mentoring within their workplaces, while others had sought support and mentoring

outside their healthcare facilities. However, for those whose experiences had been largely negative, the issue of race emerged as a crucial factor.

All of the participants in the study voiced their commitment to mentoring members of their staff of all races. They indicated that while Black subordinates were quicker to seek mentorship, Whites eventually did so as well.

Other participants perceived they had an adequate support network within their organization, and that their immediate superior was available to them when necessary.

Gloria, who was encouraged to return to school and has earned a Bachelor's and a Master's degree, expressed positive feelings about her mentoring experience:

“Understanding that there are also financial barriers with regards to the structure and ministry guidelines, the budgetary constraints etc; there may be things that I have asked for and am not able to get it” (9/7/05).

However, 13 of the participants indicated they would like to have had a formal mentorship, and felt it would have improved their overall working experiences. Five of the women did not ask their immediate superior for support, but instead turned to colleagues they were comfortable with when they needed assistance. Others said they had to, ‘fly by the seat of their pants’.

Almost half of the women (7) felt compelled to go outside their own organization for mentoring relationships to develop self-confidence in their leadership roles, and also for personal support with conflicts and sensitive issues such as racism and discrimination on the job.

Susan, who has been in a nursing leadership role for almost 20 years and holds a PhD, indicated that the reason she sought external mentoring was because in her work

experience, “most of the people are not as qualified as I am, and therefore cannot elevate me beyond the level they are at. My mentoring is always external” (3/5/05).

Diane, who has held various leadership positions for over 20 years, and holds a Master’s degree in education, reported having several mentors outside her organization, and credited one for all she has accomplished in her career:

Diane: I have a mentor that I met at one of the colleges, and I am in touch with her. Even when I change jobs I always check with her. Everything I have achieved, she has been a part of it. The vice president from my first management role, I am still in touch with her and talk with her monthly. I also have two retired Black nurse managers who are also my mentors. (28/5/05)

This trend by some of the participants to seek mentoring beyond organizational confines emerged as being particularly salient in regard to painful issues involving racism within their workplaces.

Christine, who has been a nurse leader for almost 16 years, was asked if she believes race factored in her not receiving formal support and mentoring when she was first hired in the nurse manager role. She stated:

Christine: On the whole, it was not available, but I think the people in the majority, the Whites, always seem to do that little bit better, and people seem to gather them under their wings a whole lot quicker than they would somebody in the minority. (3/9/05)

This senior nurse leader was then queried about whether she felt this lack of mentoring could negatively affect her success as a nurse manager.

Christine: One would then have to ask the question, if the support is not there, and you want them to do the role, what would you expect? Either they have to find their own resources to support them to be successful in the role, or they are going to drop. It is the sink or swim mentality. (3/9/05)

Margaret, a clinical coordinator with similar responsibilities as a nurse manager, was asked whether she received mentoring similar to White coordinators. She explained

that there is only one other coordinator, and that, "...she is White and has been in the role for a very long time, and she certainly carries a lot more clout for things that she wants than I do. I have not been in this role as long as she has been" (17/5/05).

Ten of the women mentioned that they relied on mentorship and support from women from their own racial background.

Alison: I have had a lot of people from my own racial background that mentor me on a personal level. Looking back, I have had support from other Black female nurses. Would I actually call it mentorship? No. I would call it support. If I needed something I could go to them. This is both internal and external. My biggest mentor is my mother because she has always taught me that the colour of my skin is never an excuse for any of our family members. We could not say we cannot do something because of the colour of our skin. We were not allowed to say that. What we were allowed to say was, I did not succeed but I will try harder the next time. (3/6/05)

However, although 14 of the participants in the study indicated that they would be more comfortable with same-race mentors, typically Black nurse leaders find themselves not having other racialized colleagues to interact with in the workplace.

A relatively small number of participants (3) reported they have received effective mentoring from White mentors. Alison, one of the women recalled that, "It was a White female who gave me my first job in nursing. She approached me and a group of people she wanted to be her rising stars, and I felt fortunate that I was among the group" (3/6/95). For these women, their perception was that their race did not negatively affect their experience with their mentors, all of whom were White women. In fact, all of these women (the protégés) indicated that they had felt comfortable being open and transparent in the relationship. Most of the women perceived their mentors to be "helpful", and indicated that they regularly shared pertinent work-related information that enhanced the protégé's job performance.

One-quarter of the participants (4) perceived the absence of access to informal or formal mentors, or a mentoring program, was setting them up for failure in their role as leaders. While some of the participants felt that they did not need formal mentoring, for others, this lack of support led to undue stress and performance anxiety.

Only a small number of participants (3) said that they had maintained ongoing contact with their mentoring partners. For example, Gloria indicated that for many years she maintained on-going contact with her mentor, and that it had assisted her career development.

Participants in the study were asked if they had opportunities as nurse leaders to mentor subordinates and help build their leadership capabilities. All the women felt providing mentorship support to their staffs was an important aspect of their roles as nurse leaders. When asked to describe their mentoring experiences, some voiced perceptions that minority subordinates were more receptive to the mentoring they offered; others said they were able to establish meaningful mentoring experiences with both Black and White subordinates. Susan, who has worked as an instructor for nursing students, said: "Yes, I do that all the time, and yes it is received" (3/5/05).

Elizabeth, who holds a leadership position in nursing education, made a similar comment:

Elizabeth: Yes, actually I have been mentoring one person; she has done her bachelor's and is now working on her master's, and I have other people whom I would say are not in a mentoring position, but probably in a coaching and development position. I am an advocate for students and I try to be there for the students. (13/6/05).

Jeanette, who is passionate about mentoring frontline staff, discussed her perception:

Jeanette: I would certainly say that with a number of Black female nurses, I have purposefully set out to mentor them because I see a lot of potential in them, but sometimes they would not take the opportunities that I feel they could, and I encourage them to consider trying those opportunities. Some of them have been successful, and some haven't, and a couple of them have said I am comfortable where I am, thank you very much. (13/8/05)

Participants were also asked if frontline staff were receptive to the coaching and mentoring that they provided. Lucy, who is very interested in nursing education, said "Yes, very much, and usually Black people come to you a lot" (11/8/05).

Similarly, Martha, who is active in professional nursing activities outside her workplace, perceived that the Black nurses, more often than Whites, sought mentorship:

Martha: I find that the Black nurses turn to me more so than to my White colleagues. After a while they do, and they are open, but initially there is some reservation. But the Black nurses they are quite free, and they will come to me before they go to my colleagues. Again it could be because of the feeling that they will be accepted and not judged. (30/6/05)

While most of the participants (13) perceived being treated differently by Whites, in particular coworkers and immediate supervisors, a few (3) said that this differential treatment often emanated from underlings from their own ethno-racial background.

Theme #3 - Perceptions of Invisibility and Unimportance

Tellingly, a number of participants expressed feelings of invisibility and being ignored in the work environment. Lynne, who has extensive clinical and administrative management experience, spoke at some length about being ignored by patients and families. Lynne indicated:

Lynne: I find that if patients and visitors come to complain about a Black staff member, with some of them it is as if their assumption is that I am not going to listen to them or respond to their concern because this is a Black person. Sometimes they go out of their way not to use the term Black, and they use all sorts of language to talk around the issue. Then I have to go into a filtering

process, what shift was the person working...etc. Sometimes, someone will speak to me in a condescending way, and it is almost a demand: this is what I want and now make it happen, and if you don't I will climb over you and go to the next level. (3/7/05)

Although more than half the women (11) perceived they experienced some difficulty establishing positive work experiences with White coworkers, the remainder (5) perceived they had good working experiences. Many of these participants perceived the onus seem to rest with Blacks to establish and preserve harmonious working relationships.

One participant mentioned that on several occasions she invited White colleagues to join her for lunch and more often than not, her invitation was turned down with one lame excuse after another. Diane went on to say, "To make matters worse, I get to the cafeteria and they are having lunch with other White colleagues, and then have the nerve to ask me to join them" (28/5/05). When asked how she felt about her experience, she replied: "Sure you feel slighted but I don't let it worry me, it's their problem -- not mine" (28/5/05)!

Theme #4 - Perceptions of Needing to Prove Themselves as Leaders

The study participants were asked several questions to elicit their definitions and understanding of leadership, and their descriptions of how it factored in their roles as nurse leaders. They were also asked to explain the various challenges, if any, they experienced as leaders, and the extent to which their performances were affected if barriers were present. The responses varied, although many of the participants reported some difficulty asserting their leadership. In addition, there is evidence to suggest that it

is common for Black women in leadership roles to have their authority undermined, challenged and/or disrespected, and their decisions criticized (Bell & Nkomo, 2001).

When Mary, who is a nurse manager of a busy patient care unit in a large acute care facility, was asked which aspects of her role she defined as leadership, she replied: "Budgeting, mentoring, coaching, professional behaviour...it is all leadership" (31/5/05).

Heather who is responsible for a large nursing and support staff, defined leadership as "Having a vision, being able to work with individuals, influencing, and supporting growth and development" (2/6/05).

Lynne, a nursing director responsible for several patient care units and programs, commented that for a long time she confused leadership with management, although there are some elements that are intertwined. When Lynne was asked if it was more difficult for a Black person in that type of leadership role to lead, she stated:

Lynne: Yes, it is. Leadership is very hard whether you are Black or White. Leadership is not easy. But because society does not normally see Black people as having power and people who should be in charge, therefore when you come into this type of role, there is this notion that you have to prove that you should be here. Sometimes you get a lot more challenges around what it is you have to achieve. (3/7/05)

Martha, who provides leadership to a large staff of nurses and clerical and service staff, similarly talked about her style of leadership, and indicated that she had an open door policy, allowing her staff to approach her freely and openly.

Martha: I am not attached to any change that I have implemented. Leadership is certainly being supportive of your staff, and helping them to grow, sharing their successes and encouraging them to be successful, putting them into positions in which they will succeed. (30/6/05)

When I asked Margaret who coordinates patient services and clinic and staff schedules whether or not her staff perceived her as a leader, she replied, "I am sure some

do” (17/5/05). And when prompted to provide a reason why others did not, she said, “Hard to say, but I guess there are folks with their own criteria of what it takes to be a leader” (17/5/05). Margaret was then asked: “If I walked on your unit today, would I glean from a discussion with your staff that they know you are the leader of the group?” Margaret affirmed that they would, and went on to say that for the most part, her leadership was recognized and accepted. She explained:

Margaret: The few who did not, had an inability to accept me as the person with some measure of control to supervise. There are also those who have difficulty conforming to a hierarchical chain of command, and would prefer to deal with someone else instead of me, although they acknowledge that I am in the position of authority. (17/5/05)

The perception of Christine, a senior nurse leader, is that her racial background impacts how her leadership was received by the staff. Christine had this to say:

Christine: You are always conscious of how you share information as a leader, and the position you take on certain issues or other people’s actions. It is very interesting how people accept or reject your leadership; for some people, they nonverbally communicate you should not be telling them what to do. Conversely, others try ways to undermine your authority. You need to be knowledgeable, strong and self assured. (3/9/05)

Theme #5 - Perceptions of Racial Difference in Career Progress

Although the participants in the study were already in managerial and administrative positions, opportunities for further career advancement were nonetheless important. Participants were asked about their perceptions of potential career opportunities, and whether or not their racial identity would be a barrier for those who desired to advance.

Several participants perceived that they had opportunities for career advancement equal to their White counterparts, but a good number felt that their race was a definite

impediment. For example Christine, with almost 16 years as a nurse leader, reported that she had been successful getting all the jobs for which she had applied. When asked if she thought her racial identity impacted her career opportunities, she responded:

Christine: Based on the number of years I have lived in Canada and how I have climbed the career ladder, I have done fairly well in the sixteen years that I have moved from staff nurse, to charge nurse, to my present position. So I don't think I could have done it any faster while also getting the educational qualifications that supported me moving into those roles. Do I see myself getting beyond this? Perhaps not, because I have yet to see -- although my experience is limited -- I have yet to see a Black CEO. (3/9/05)

Heather, a nurse manager for approximately eight years, had this to say:

Heather: In terms of moving into the role of nursing director, individuals encouraged me to take it on, and they were Caucasian and spoke about my abilities; they felt that I had the abilities to manage in the role and to handle difficult situations. Because a lot of it is human resource issues, dealing with people, I was told that I had the ability to do that. (2/6/05)

Alison, another participant, also did not perceive that her race limited her opportunities for career advancement, and certainly had not been a barrier to getting her current position as a nurse manager. When asked if she perceived herself as having opportunities equal to her White counterparts, she responded: "Absolutely. There were two positions that my colleagues encouraged me to apply for" (3/6/05).

Five of the participants perceived that their race did pose a barrier to further career opportunities within their organization. There was no broad consensus as to how race would factor in; self-doubt, absence of Blacks at the senior level(s), lack of opportunity, lack of confidence, not ready and no consideration given to senior roles were implicated to varying degrees.

Gwen, who has been in leadership positions for close to 30 years, said:

Gwen: There is a real fear of being rejected because of who I am as a Black woman. I might go through the exercise of applying, but with no conviction that I

will be called for an interview. Even if I do get an interview, I doubt that I would be the candidate that would be selected. (11/5/05)

When asked if she feels Black women tend to carry the burden of race on their backs, which can be a barrier to them getting ahead, Gwen replied, "I think most do. I certainly do" (11/5/05).

Other women, through their comments, revealed doubts that their organizations were receptive to the advancement of Black women.

Lynne, who has extensive clinical and administrative management experience, was asked if there were opportunities for her to attain senior level executive positions.

She remarked: "I doubt it" (3/7/05). When asked if race would be a factor, she replied:

Lynne: I think race is certainly a factor. When I go to meetings -- and it has been the case all my life -- I am generally the only Black person sitting there. And yes you could say that not enough Black people are interested in these positions, but I would not say so. Sometimes I think assumptions are made about Black people and about what we will do if only we have more power. And so I sit in rooms being the only Black person, and they are going on and on about having more representation from various ethnic groups, but I am looking at the room and seeing all the leadership at the senior level, and you will not see a Black person. These positions are offered through networking; it is all about whom you know and who knows you. We, meaning Blacks, don't have networking opportunities the same way. In order to get to the higher level you really have to be a part of the game. (3/7/05)

When Lucy, who has held several informal and formal leadership positions in the same acute care setting, was asked if she perceived race as a barrier to her career advancement, she remarked:

Lucy: I don't think there is opportunity for me here. I believe the organization has a limit to how many Blacks they allow to advance up the career ladder. Professionally, I intend to go further in nursing, but in this organization I don't think I will be here long enough. Secondly, my advancement has been affected by the number of applications you have to submit before getting a job. I didn't just get this position overnight. (11/8/05)

A small number of participants (2) also indicated they were not interested in career advancement because they were near the end of their nursing careers. Elizabeth, who has been at her present place of employment for many years, said:

Elizabeth: Not at this point, because I feel now that I am in the closing years of my career I need to do what I do well now. I am looking at retirement in a couple of years, and so I haven't gone about seeking advancement. (13/6/05)

There were wide variations in the participants' responses to the two related questions: What are your chances of career development in your workplace? Do you feel that your racial identity limits your opportunity for career advancement? Nevertheless, 14 participants perceived that racism and racial stereotypes impacted the career advancement of racialized nurses, including those in leadership positions. And ultimately, the majority of the participants perceived that they had worked very hard to achieve their leadership positions, earn the respect of their colleagues and be considered competent in their job performances.

Sub-Theme - Perceptions of Racial Identity as a Benefit or a Liability

To understand the participants' feelings about whether their racial background has worked for or against them, they were asked: Have you had experiences when your racial background has worked in your favour, or as a liability, in your role and in the workplace environment? Participants spoke of constantly having to prove themselves, and losing to less qualified White candidates in job competitions. In some situations, race obviously plays a role in determining candidate suitability for certain jobs. Even though a racialized candidate has the required job experience and qualifications, they are turned down and the job offered to a less qualified person, who happens to be White. In

many instances, interview panels generally do not have minority representation, and consist primarily of Whites. Therefore, it is not surprising that hiring decisions made by most interview panels are biased in terms of a preference for people of their own ethno-racial background...i.e. White.

Linda, who has held several leadership positions with increasing responsibility in a large acute care organization, said: "I think my racial background is a liability in the workplace. Sometimes it is the surprise I get when people meet me. A number of people have said I didn't know you were Black" (13/7/05). In response to Linda's comment, I asked: "Is it that what they see is not what they heard?" Her response was: "Exactly! And often a comment such as, "I would never know you are Jamaican" (13/7/05)! Linda's interview excerpt illustrates a perception amongst Whites, that all racialized people will speak with an ethnic accent. Therefore, in Linda's case it was expected that she would be a non-racialized person because of her accent.

Gloria, who has worked in management positions for four years, had this to say: "I can think of an occasion when I was being interviewed by the recruiter, and later being told of the decision not to proceed, and I know that the person who got the job was less qualified than me" (9/7/05). When I asked Gloria why she didn't contest the process, she mentioned it is "a no win situation." In her words, "Human resources are known to present a convincing favorable argument to support their decision" (9/7/05).

Theme #6 - Perceptions of the Role of Class and Gender in Participants' Work Experiences

As I mentioned earlier, the role of gender and class was not a major focus of this study. All the women in the current study were asked to describe what they understood

by the term 'class', in defining their own social class, and to describe the agency of class in their experiences as Black nurse leaders.

There were differing opinions among the study participants regarding their perceptions of class status and how it impacted their workplace realities. While most of the women were initially reluctant to categorize themselves as middle class, and somewhat uncomfortable discussing the class issue, the majority agreed that sociological definitions that encompass occupation, education and income are valid factors in determining social class status.

Although the study participants viewed themselves as being 'middle class', for the most part they stated that they were not on 'on a par' with White colleagues. The literature suggests that in our class-conscious society, people of colour, particularly Blacks, are generally stereotyped as 'working class'. There is evidence to suggest that, within the social class strata, Black women are typically perceived as lower class compared to White women, even if they have a similar or more advanced level of education, profession and earnings, and live in similar neighborhoods.

Gloria, one of the participants, defined herself as "probably middle class. I don't have a background of old money. Whatever I have, I have worked very hard for" (9/7/05). Another participant Martha, who is married to a physician, said, "I would say I am middle class" (30/6/05). Lucy, who came to Canada at a young age, commented that, "I think I am middle class" (11/9/05). When Lucy was asked to define middle class, she said, "I don't know if I have any specific indicator to define that, but if you look at it from a geographical or global perspective, it has to do with your employment, education, socialization, and where you live" (11/9/05).

The study participants were asked: “As a Black middle class woman, do you think you are seen on a par with a White woman of similar social class?” From the majority of participants (13), the most prevalent answer was “no.” In fact, many women perceived themselves stereotyped as working class because of their racial background.

One of the participants, Lynne, who has spent over 15 years in progressive leadership roles, said: “I am not evaluated on par. I don’t think we [Blacks] are anywhere near where we will be evaluated on par. I have gotten to where I am because I have ability and because I have worked very hard” (3/7/05).

Christine, a director of nursing, stated:

Christine: Definitely not! I think anyone who sees us as equals has got their eyes closed. I think the glass ceiling is certainly there to fool you. The illusion that you are at the same level is there, and if you try to say otherwise, people think you have a chip on your shoulder. (3/9/05)

Another nurse manager participant, Martha, commented:

Martha: OK, to be more specific, I happen to be married to a physician, so I find once somebody finds that out -- I don’t usually tell people because I want to be seen as my own person -- but once it is found out, you turn up at a social event and there is a difference in how people treat you. That actually annoys me so that is why I don’t tell people. It doesn’t make a difference with nurses, but it does make a difference with physicians. I am thinking of a particular example, and I am not going into detail, but the minute that person found out that my husband is a physician, their attitude towards me changed. (30/6/05)

Because gender all too often emerges as a significant factor in workplace experiences, I asked participants if they had perceived that they encountered difficulties or challenges because of their gender identity. When I compared gender to other differentially related factors, it does not seem to emerge as a salient issue or play a role in the women’s day to day experiences. This may be primarily because, as one nurse leader,

Pamela stated, "I suppose given the nature of our work and because nursing is predominately female...." (14/10/05).

Elizabeth's narratives seemed somewhat equivocal in her response to the question related to gender. Her response was: "So I cannot say so for sure. However, in nursing I can say male nurses do go up the ladder faster than female nurses" (13/6/05). It has been noted in the literature that in situations where gender is an influential factor, racialized nurses find themselves in an unfortunate 'double jeopardy' position...female and Black.

Strategies of Resilience and Coping

The participants' were asked to describe resilience and coping strategies they used when confronted with racism and discrimination, and to maintain personal and professional integrity in the workplace. Participants' perceptions varied, but some strategies, whether proactive or reactive, were perceived as beneficial for dealing with discrimination issues in the work environment.

It was revealing to hear how the women in the study were affected by racist behaviour and differential treatment. Several of them broke down in the course of their interviews, and needed to pause to compose themselves. Lucy's response as to whether she was happy in her role as a nurse manager was the admission that, "No. I hope you never think I was. Did I ever give you that impression? I never associate work with happiness. I look for happiness elsewhere" (11/8/05).

Gloria, who is very active in her church said:

Gloria: You try to find out why things happen, how we can work better together, what the issues are. I find I am the one who always has to make that effort, and I don't think that is right because I don't think it is my issue, but I make the effort.

I also speak to my supervisor about what is going on, and then I find someone else to speak to who is neutral. (9/7/05)

Christine, a nursing director, provided the following comment regarding coping strategies: "There isn't a cook book of recipes to use that is going to help any one of us in coping with our situations. I think you have to look within yourself, and build some of those coping strategies of your own" (3/9/05).

The following excerpt illustrates Christine's comment that there isn't a singular anti-racism strategy for dealing with racism, but rather each individual must act accordingly, having evaluated each individual situation. Martha, a light-skinned Black woman, expressed her opinion:

Martha: When you face a situation, sometimes you need to see whether or not it is racially motivated. There has to be that distinction. I actually do that a lot. I don't want to jump in and raise the race card when it doesn't have anything to do with race. (30/6/05)

Other women in the current study were asked what strategies they perceived as to be particularly useful in dealing with racism and discrimination in their workplaces, and the resulting anger, emotional trauma, and resentment. The women claimed to use various coping strategies to deal with their negative work experiences; as an example, one of them talked about staying confident and not immediately attributing race to every circumstance.

Gloria commented: "The one word that comes to mind is fairness. Being fair to everyone, and treating everyone equally regardless of their colour, creed or race" (9/7/05).

Pamela, in an acting manager's position for just over a year, identified the following strategies:

Pamela: I would look again to find out where we can find support, where we go to get the kind of support to be able to help that person deal with those issues, and whether I can talk to that person to find out what the issues are. (14/10/05)

Pamela was asked to elaborate and she said: “It may be something I can help them work with. It may mean they need to address the issue, because I think the more you sort of work within that issue, then it supports the environment for people to say, yes, they can continue to do this” (14/10/05).

It is evident that one of the strategies employed by Pamela is to take inventory around the work environment, to find out where the sources of strength and support are, and to build on them.

Although several participants were unable to define deliberate or specific personal strategies used as coping mechanisms, it did become clear from many of the participants’ narratives that having a reliable support system was essential. Over one-third of the women (6) reported that having strong network and support systems outside their organizations, including family members and friends, helped them deal with issues and concerns related to their working environments. Jeanette commented: “My family is very important to me, my husband is very supportive” (13/8/05).

Susan expressed her opinion:

Susan: You need people you can bounce things off. If you have a hectic day and don’t have someone you can talk to internally, then you need someone externally to discuss things with. This person will help to give you perspective as well as help you stay in the job and remain healthy, and make progress. (3/5/05)

Linda, who has held various leadership roles, stated: “If internal supports are not working well, you had better have external support. If not, you will not survive in this intense work environment” (13/7/05).

Participants also reported that they chose not to discuss personal issues with women of the dominant culture, because their belief is that Black women and White women have dissimilar experiences when it comes to racial identity. The perception amongst the study participants is that racialized women have a shared perception and understanding of racism and discrimination. But, most of the women believe that their White colleagues do not truly understand the issues confronting Black women in the workplace. A small number of participants (5) in the current study also reported high stress levels because of discriminatory attitudes and behaviours they encounter from some of their White co-workers.

Gloria was asked if she perceived that she would be comfortable discussing issues of discrimination with her White colleagues, or with another woman of colour. She replied that she “would choose a woman of colour. I think I have spoken to one person from the dominant group, and don’t think they can comprehend” (9/7/05). Gloria, like many other Black women, does not feel that women from the White dominant culture are capable of understanding her issues and concerns, especially her day-to-day experiences of racism and discrimination.

I asked Christine if she would be comfortable speaking to a White colleague about issues related to race and racism, or would prefer to seek support from another racialized colleague. Her response indicated a clear choice:

Christine: Certainly not with my White colleagues because that always resulted in people talking about you or claiming that you have a chip on your shoulder and seeing things that are not there. My support would be going to a colleague of the same racial identity as me. There I would feel comfortable and safe to be able to voice my frustration. At the end of the day, really, whether it is the right thing or not, certainly I look to my colleagues of the same racial identity for support rather than a White counterpart. (3/9/05)

Half the participants (8) perceived that they would be more comfortable discussing issues related to race and racism with other Blacks external to their organizations, or with family members. Only one of the women out of the sixteen who participated in the study mentioned that she was embarrassed disclosing her genuine feelings about her encounters with discrimination to Black coworkers in the workplace.

On the other hand, participants (5) reported feeling supported by some members of the White dominant culture in their work environment when dealing with sensitive issues, and others claimed they had access to informal and formal support from their White counterparts and supervisors.

Margaret, who is an active public speaker and presenter outside of her job as a clinical coordinator, stated:

Margaret: I would raise the issue with a White woman if it related to an advantage that they were getting that I was not. If it's not blatant in terms of race, I would ask the person why she is getting something that I am not getting, and ask her to tell me what she has gotten based on her decision to go this way, and I would say I did that and I was not able to get that. Sometimes they will try to be helpful by saying you must talk to this one and that one. (17/5/05)

Because many participants had difficulty identifying personal strategies used to cope with perceived discrimination in the workplace, the question was rephrased and the participants were asked what strategies, if any, they would recommend to another Black manager or a manager of colour facing workplace discrimination. Heather, the youngest of the participants, gave a detailed response:

Heather: I think it is important to have a multi-cultural mix of staff on the unit which hopefully helps to minimize clichés and opportunities where discrimination could occur. I also engage regularly with the human rights and diversity advisor. Recently she has been on the unit to talk to us about the human rights and diversity policy, and what that means for individuals in raising awareness about things that could constitute discrimination. Sometimes it is really hard to put your

finger on it, and if you raise the issues, people will say, what are you talking about? So I deal with that personally in that I may become quiet. (2/6/05)

Heather was asked whether her use of silence was a coping strategy, or a response to the pain caused by her experiences. She replied:

Heather: All I know is that I felt uncomfortable. And I also know as I began reflecting on it, I was being treated differently, although I couldn't put my finger on it. I was feeling very uncomfortable; it certainly affected our working relationship and the effectiveness of that. I will respond to questions and give guidance and support if I am asked, but I am not going to volunteer anything. That is one personal strategy that I am going to use to deal with such situations. (2/6/05)

In Heather's case, pulling back could be perceived as a self-preservation strategy, and her way of taking control of the situation and protecting her own interests.

Consistent with the above argument, approximately 6 of the women had difficulty acknowledging manifestations of racism and discrimination in their workplace. In fact, some of the women were unable to succinctly articulate their experiences, and at times it was necessary for me to rephrase related interview questions to get to a clear understanding of their viewpoints. Other participants had to be asked repeatedly to elaborate on their responses.

For one-quarter of the women (4), their responses to specific questions seemed to contradict previous responses to similar questions. Additionally, 6 participants seemed willing to overlook or rationalize negative discriminatory behaviours directed towards them in their workplace, and attributed such behaviours to some factor other than race and racism.

As Gwen, one nurse leader claimed, it is important not to "go there first, but to look for other reasons that could explain the behavior" (11/5/05). Elizabeth, another nurse manager commented that "...it is important as a people [Blacks] not to be seen as

jumping to racism as the first thing, I think you have to explore the reasons why”

According to Elizabeth, one of the nurse leaders in the study:

Elizabeth: I have difficulty labeling racist behaviours as racism. Although I wonder if it's racism, I find myself reluctant to label it as such. I find myself considering what the fallout will be, and I am reluctant to name it [racism] because that is just the beginning of another journey to resolve that issue. (13/6/05)

I explored the extent to which participants felt vulnerable in their work environments. Several participants in the study spoke of being reluctant or finding it difficult to challenge racist attitudes and behaviours, perhaps because Blacks are not considered equal to their White counterparts, and are typically viewed by Whites as aggressive and, therefore, more confrontational. Several of the women said they felt vulnerable because of their non-union job status and their racial identity. Additionally, 9 of the women mentioned they were reluctant to openly address racism and discrimination in their work environments because they feared losing their jobs or being labeled as 'troublemakers'. On the other hand, a number of women reported addressing the issues of racism and discrimination in spite of possible untoward consequences.

The participants agreed that it is not always easy for managers to openly address issues of discrimination at the table, especially because of their non-unionized positions.

Pamela, who is married with a family, commented:

Pamela: Yes, I do know that for economic circumstances people need their jobs. But at the same time, my thinking is, although I do need my job, I'm also not going to be able to tolerate that kind of behaviour and those kinds of abuse, because then sooner or later there's going to be burn out. (14/10/05)

Some of the study participants chose self-silencing as a coping strategy in response to perceptions of discrimination and unfair treatment. hooks (2001) contend that in spite of Black women's silence, they are very much aware of the societal

ideologies and structures that privilege White women's leadership. The women in the study described feeling uncomfortable about confronting acts of discrimination and racism. Many talked about having to decide whether to ignore or address these issues.

Strategies Towards a Non-discriminatory Nurses' Workplace

An important goal of this research was to identify strategies that would improve nurses' workplace environments. The 16 Black nurse leaders who participated in the study were therefore asked several open-ended questions about what workplace changes would improve their quality of work life, as well as what approaches they thought employers could use to create an inclusive, non-discriminatory work environment. Finally, they were asked whether it was important to increase the numbers of racialized nurses in leadership positions.

Participants generally felt that the future of healthcare in Canada was dependent on combating racism and other forms of discriminatory practices in the healthcare system and in nursing. They further emphasized the importance of creating work environments that embraced diversity management and anti-racism practices. But they expressed frustration about expectations for racialized individuals to be responsible for educating Whites about what constitutes racist behaviours and racism. They felt strongly that Whites should take responsibility for being educated about racism, and be held accountable for their racist behaviours. Most agreed that, although there are brief spates of attention given to issues of race and discrimination in healthcare institutions and settings, nevertheless, it is reasonable to argue that sufficient and sustained efforts are not given to improving Black and other racialized nurses' deteriorating quality of work life.

The nurse leaders of the study said that Canadian nursing organizations, professional associations and nursing leaders and administrators should be held responsible and accountable for racist and discriminatory practices within their institutions. Furthermore, they must demonstrate commitment to eliminating racism and other inequalities in the nursing work environment. They emphasized that nursing and healthcare leaders and administrators should move beyond lip service to the problem of racism and discrimination in the healthcare work environment. Alison, who works in a large teaching hospital, said:

Alison: Every institution has its mission and values, and this institution has strong values that are well articulated but not always practiced. I think people need to walk the talk and let employees know that there is an open door, that if you are feeling that you are being discriminated against you have an avenue to address it. (3/6/05)

The women talked about the urgent need for healthcare organizations to develop and implement policies and processes that are effective, to ensure an inclusive and non-discriminatory workplace environment for all nurses regardless of their racial identity and professional status. They perceived many of the existing policies as ineffective, and 'without teeth'. As Lucy explained:

Lucy: When the human rights director is worried about her job, she has to work within the philosophy of the organization. The organization's philosophy does not support inclusiveness. Although issues related to racism and discrimination may be identified, they will never be resolved. Lip service is paid to these issues. And, if you are not careful, at your expense. Chances are you may be implicated by those who are there to support you in dealing with these issues. (11/8/05)

Across the board, participants said that they would like to see increased racial and ethnic diversity at every level of the nursing profession, to adequately address the needs of diverse minority populations, and to represent their concerns and issues. Pamela, one of the nurse managers, explained:

Pamela: It is really about trying to make it better for the patient. Culturally, if you are looking after patients on a unit and the nursing population doesn't have a clue where they are coming from and what their issues are, then we are not giving them the best care. (14/10/05)

Participants felt there was a need to ensure ethno-racial diversity within the various job categories. However, currently the CNO does not have a process or strategy in place for assessing the ethno-racial profile of nurses in Canada. Consequently, very little is known about the ethnic or racial composition of the nursing workforce. To address this concern, the participants recommended that the CNO take the bold step of implementing a process for collecting racial and ethnic data on the nursing population.

When Martha was asked how important it was to have diverse leadership in nursing, she said: "We all bring different values to the table, but we don't have sufficient diversity in leadership to know what the patients want" (30/6/05). Heather said: "senior administrators should ensure that there is a greater representation of racialized nurse leaders to reflect the diverse populations that access healthcare services" (2/6/05). All the participants emphasized that this initiative was crucial. To this end, they proposed that the CNO also advocate for healthcare organizations to conduct workforce surveys, and collect ethno-racial data on the nursing workforce, in order to detect racial and ethnic disparities in the various leadership positions. As mentioned earlier, accurate data are necessary to reveal inequities in nursing leadership positions based on race and ethnicity, and to measure the extent and impact of discrimination in the profession.

Jeanette, who has played a major role in political activities related to nursing, summed it up beautifully:

Jeanette: I definitely agree we need more racialized individuals in leadership. But I believe the best person should get the job because they have the ability, and not because of a quota. I believe in being able to help employers promote Black

women, but not with them having the attitude that if they have one in a position that's enough. I think it's not only in healthcare; it's also in education and some other areas. I also think we as Black people have a role to play, and not just stand in the corner and expect it to come to you. If you get that opportunity, don't feel inferior and let things happen in a negative way. Be that voice, be proactive, be involved and demonstrate. Because I think as you do that, more Black women will be in positions of power to be able to make a difference and bring other people along. (13/8/05)

CHAPTER SIX

DATA INTERPRETATION

Introduction

This research study has delved into the complex experiences of 16 Black female nurse managers in several healthcare facilities in Metropolitan Toronto. The knowledge derived is crucial to the understanding of the pressures faced by these nurse managers and, even more importantly, demonstrates the need for change in a healthcare industry that perpetuates barriers and adverse workplace conditions.

In the previous chapter, the findings were categorized under themes and sub-themes that emerged from the narratives. The main aim of this chapter is to present an analysis of the themes and sub-themes that emerged in the participants' responses to the study questions and relate this analysis to the broader societal issues and implications of the findings, and their resonances with prior literature on this topic.

Exposing Racial Discrimination Effects within Canadian Nursing

It can be assumed that the participants' narratives, and the similarities found within, expose the race-based bigotry within Canadian nursing, a profession that claims to be ethical and caring. For me, the research findings bring to mind the statement of Abraham Lincoln, in his speech to the delegates at the Republican State Convention on June 16, 1858: "A house divided against itself cannot stand." In healthcare facilities, the working environment for Black female nurse managers should enable them to focus on serving patients and their families without the intrusion of race-based bigotry. However,

at present, they are more likely to encounter atmospheres of confusion and ambiguity, where their work experiences are diminished by intimidation and invalidation.

It can be concluded that the interrelation of several of the themes reveals the impact inequitable and differential treatment has had. Although these themes do not conjoin across every situation, enough of them are evident in each experience to warrant recognition and attention. Perhaps more importantly, they provide clear evidence of the racial discrimination within the profession of nursing that result in negative differential treatment of Black nurses. Furthermore, their convergence tells a story of continued oppression and discrimination.

Although more and more organizations are recognizing that the workplace environment should be free from harassment and discrimination, with zero tolerance towards racism, the internal way of doing business in many Canadian workplaces — including healthcare workplaces — has long been an unquestioned and generally accepted practice. And, it is widely acknowledged that the systemic barriers have had a profound effect: the denial of minorities' equal rights and opportunities in the labour market, when compared to members of the dominant culture (Lopes and Thomas, 2006).

The women interviewed in the current study were aware of their unique positioning as Black nurse leaders in a predominantly White management workforce. It is noteworthy also that many of the women said their participation in the study resulted in an increased level of self-awareness about their work situations. Most of the women in the study acknowledged their marginalized positions in their roles as nurse leaders because of the dynamics of race and racial oppression in their workplace environments. The participants' stories provide a snapshot of their day-to-day experiences of

recognizing and dealing with racism in the workplace. Hopefully, the information and insight garnered from this research can serve as a blueprint for an anti-racist praxis in the nursing profession.

Differential Race-Based Treatment and Biases

The present research focuses on racialized nurses in leadership positions, Black women who, despite the odds, have broken through the race and racism barriers and attained managerial positions. The question is: are they treated differently than their White colleagues in similar roles? The data revealed similarities in the participants' responses to this question. It's significant that there was consistency among the participants' responses, despite the fact that they work in several different healthcare organizations.

One of the prominent perceptions that emerged in this phenomenology research was a pattern of subtle race-differential treatment from coworkers, supervisors, physicians, patients and patient families. Negative stereotyping, racial discrimination and biases in the labour market and workplace environment lead to differential treatment and experiences for non-White people (Teelucksingh & Galabuzi, 2005).

Differential Treatment by and Biases of Physicians

Although effective communication between nurses and physicians is essential for the care of patients, anecdotal information and research evidence suggest that it is often influenced by gender and class differences (Zelek and Phillips, 2003). Many nurses perceive there is an unequal power dynamic between themselves and physicians, with

physicians having more power and autonomy in their professional roles than do nurses. But the hierarchical relationship between nurses and physicians is also informed by race differences, and reinforced by racial stereotypes of Black women.

As we have seen in experiences like Lucy's, whose greeting to a White physician was ignored...repeatedly, it is the internal racism, more than the sexism and classism, that is a persistent problem in these study participant's everyday work experiences. Their stories reveal the "...subtle ways in which they were slighted, excluded or ignored" (Lovelace & Rosen, 1996, p. 5).

Many of the participants reported that they did not experience differential treatment from the physicians in their workplace, perhaps due to the fact that through their performance, they had been able to demonstrate their competency as managers and dispel any negative stereotypes about Blacks in this role. It could also be perceived that class overrides race in the nurse managers' experiences with physicians. This said, the majority of participants also reported that, while race was a factor in determining nurse-physician working relationships, their perception was that gender and class differences were perhaps the most salient influential factors. This finding concurs with that of Zelek & Phillips (2003) that suggested physicians' authority and power is linked to social class and gender, notwithstanding the fact that race adds another layer of complexity to the work relationship.

The data analysis revealed that many of the participants perceived they were bypassed or excluded from decision-making processes by physicians. Some also perceived that physicians did not think racialized nurses were knowledgeable nor had the ability to carry out the functions of a nursing leadership role. In other words, those

individuals considered more suitable for leadership positions are constructed within gendered and racialized contexts. In the context of race, the participants perceived that White women are perceived as the best, or more suitable than Black and other racialized women, to fill positions of leadership. In regards to this study, the fact that more White women than Blacks hold positions in leadership confirms that White women have more advantages than their Black counterparts because of White-skin privilege.

Arguably, racialization in most organizational structures and processes tends to determine organizational fit and leadership suitability. Processes of racialization imbedded in most organizations influence how management competency is constructed. In this context, Blacks and other racialized minorities are perceived as not having leadership skills and abilities; conversely, Whites are perceived as having the skills and qualities necessary for leadership. In fact, the literature consistently shows that Black managers received less favorable assessments of their leadership skills and abilities than White managers.

I would like to suggest that Heather's experience of not being heard at meetings stems from the fact that, although she has been in the manager's role for a number of years, and is confident in her ability to carry out managerial responsibilities, on account of her race and ethnicity she is still perceived as less able than her White counterparts to offer relevant suggestions. Stereotypes related to managerial performance seem to originate from the common perception of Whites as more competent and better able than Blacks to handle managerial functions and responsibilities. Black women in leadership are often perceived to be less qualified than they are. It is not surprising therefore that Heather's suggestions were not given the same level of credibility as the suggestions

made by her White colleagues, even when they were similar or the same in context. Essentially, Heather's feelings of discomfort were linked to her perception that she is marginalized and viewed as less competent than White managers.

Even when racism is subtle in nature, it can have a profound effect on how individuals view themselves, creating feelings of self-doubt as well as a sense of paranoia. In Heather's account, we are able to see how racialized positioning, in the racialized social context of many workplaces in Western societies, serves to render someone like her less qualified and less competent than her White counterparts. Furthermore, Heather's experiences have forced her to be aware of the role of race in determining one's organizational fit and suitability to assume leadership responsibilities.

To make sense of Margaret's complex situation in regard to her goal of pursuing higher education, it is necessary to take an intersectionality approach for analysis. The relationships between race, gender and class created a problematic power differential for Margaret vis-à-vis the physician. From his position of White male privilege, the physician felt empowered to echo an opinion that arguably was based on racist and sexist ideologies. These ideologies construct Black women as unintelligent, and therefore undeserving of the opportunity to pursue the same level of education as White women. Margaret's response demonstrated her sense of agency to subvert a subtle form of racism that continues to blight the lives of many Black women.

Differential Treatment by and Biases of Patients, Families and Visitors

The implications of race are also witnessed in the discriminatory and often blatantly nasty behaviours of some patients and visitors. This leads one to conclude that

such behaviours simply close the circle on the interrelation of external societal racist attitudes, and internal healthcare organizational marginalization and devaluation of nurse leaders. But it is the internal racism that, although often subtle in nature, is a persistent problem in these women's everyday work experiences, more so than the external. Participants' perception of differential treatment illustrates how covert racist ideologies sustain commonly held beliefs among Whites that Blacks are not suitable to hold positions of authority, thus causing them to be disrespectful of Blacks that are in these positions.

What we see from some of the participants' negative experiences are the pervasive effects of systemic racial conditioning reflected in the use of words such as 'Black bitch' and 'monkey'. Equally telling are the comments such as, "Who does she think she is?" and "Are you one of those pretenders?" as well as "lovely little girl." These comments clearly reveal assumptions that a Black female nurse manager is an aberration, and not someone to be respected. Also Implicit in these derogatory appellations and comments are the attempts to devalue Black female nurse managers, to cast them in a role that is both demeaning and subservient.

There is, in my opinion, no doubt that that there is an urgent need for healthcare organizations to purge the attitudes of neglect, condescension and categorization that are based on the race or ethnicity of female nurse managers, whose primary concern is to provide the best healthcare for patients with whom they come in contact. While little can be done to change patients' mindsets, a great deal can be done by organizations to foster a genuinely collegial climate that rejects discrimination in its many forms, whether they be explicit or implicit.

Subtle Racism and Racial Discrimination

Underlying the complexity of inter-racial, inter-ethnic and inter-cultural workplace experiences and encounters are several layers of difference (language among them). The often ambiguous nature of these situations leaves room for varying degrees of interpretation, misinterpretation, perception and misperception. Because of the pervasiveness of racism in our society, it is not out of the ordinary for Black and other racialized minorities who experience negative and discriminatory behaviour in their everyday work lives, to characterize such behavior as racism. Hence, the old adage, 'who feels it know it.'

Perceptions of subtle forms of racism and racial discrimination commonly emerged in a large majority of the participants' narratives. In some ways, the subtle nature of discrimination makes it difficult at times to provide concrete and specific examples. This only made the experience worse for them because they generally were not believed. Blacks and other racialized minorities are often placed in the position of having to provide concrete examples to prove cases of race-based employment discrimination and, in many instances, this is difficult to do. The onus of proving racism being on the victim of racism is a rather commonplace occurrence.

After a close examination of data, this study confirms Deitch et al's (2003) contention that "...everyday discrimination is manifested at work in forms of subtle acts of mistreatment of minority group members" (p. 1300). This study confirms the assertion that in many instances the subtle racial discrimination experienced by many racialized people "...can often only be detected upon examining all of the circumstances" (OHRC, 2005, p. 24).

The Impact of Racism on Black Female Nurse Leaders

Although some participants maintained that they did not experience workplace discrimination, they nonetheless talked about specific experiences that might be perceived as instances of prejudice or discrimination. Perhaps this is the conundrum of perception versus reality. Or, one may conclude these participants simply tried to ignore or deny any experiences of workplace racism and discrimination, in an attempt to repress the emotional pain associated with being marginalized and discriminated against. In short, a coping mechanism that "...serves to distance the self from feelings of victimization" (Crockett, Grier, and Williams, 2003, ¶. 3).

The devastating impact of racism on victims is well documented in the literature (Dei et al, 2004). Experiences of racism affect the health and wellbeing of individuals who are exposed to encounters with racism and discrimination in their everyday lives (Bhugra & Ayondrinde, 2001; Williams, Neighbor, and Jackson, 2003; Cain, 2003; Utsey & Ponterotto, as cited in Crockett, Grier, and Williams, 2003). There have been studies suggesting that, "racism may be associated with severe health consequences" (Karisen & Nazroo, 2002, p. 625). Blacks who experience racism are at higher risk than Whites for health problems such as depression and anxiety, cardiovascular diseases, cancer and hypertension (Krieger, 1990; Kirchheimer, 2003).

An American study by Sewell (2005) suggests that Black workers experience higher levels of anger than Whites because of experiences of workplace isolation and negative stereotypes. Sewell further contends that racial minorities, because of their small numbers in the workplace, often experience feelings of separation and loneliness.

In other studies, racism in the work environment has been found to be extremely stressful for Black women (Alleyne, 2004; Barbee, 2002; Lopes & Thomas, 2006; Morgan, Beale, Mattis, Stovall, and White, 2000). Consistent with other empirical research, the Black women in the present study rated their work environments to be stressful because of experiences of racism that negatively impacted their quality of work life.

Confronting and naming issues of racism and discrimination in the workplace is not an easy task for racialized minority people (Dei et al, 2004). Therefore, it should come as no surprise that 13 of the 16 participants in the current study reported being more comfortable talking about their everyday experiences of racism and prejudice with Black or other racialized women, than White women. It is also noteworthy that all of these women claimed that they do not talk openly about the racism and discrimination they experience in the workplace with White colleagues or their immediate supervisors, all of whom are White, because of the fear of retaliation or being labeled as troublemakers.

Discussions pertaining to personal experiences of racism and discrimination can lead to feelings of vulnerability, so it follows that the participants “feel more comfortable with people who they perceive as similar” (Conard & Poole, 2002, p 366).

Many of the study participants indicated that without effective coping strategies, whether they be internal or external supports, it would be impossible to survive the intensity of their workplace situations. The impact of differential treatment, as revealed in the study, took an emotional toll on the women. Woven through their narratives, we can see threads of uncertainty, quandaries, ambivalence, fear and suppressed anger. It is a mixed bag of emotions that caused them to disengage from confronting situations in

which race was or could have been a motivating reason behind the adverse treatment. The reluctance by many of the participants to challenge inequities emerged from the data.

The backlash for those who challenge racism or its effects is undoubtedly devastating, and as a consequence some individuals are reluctant to expend the physical and emotional energy required to deal with each circumstance. Crockett et al (2003) found that, “Coping strategies function to actually reduce the impact of discriminatory treatment or, alternatively, constitute a short-term adjustment to such treatment, allowing its cumulative effects to support and reinforce economic disadvantage, psychological and physiological stress” (p. 3).

Even when racism is subtle in nature, it can have a profound effect on how individuals view themselves, creating feelings of self-doubt as well as a sense of paranoia. Many racialized minorities do not want to deal with the emotional pain associated with the experience of racism. Hence, many of these individuals, as was the case in the study, may sometimes attribute experiences of racism to other factors that are less emotionally traumatizing.

It is not unrealistic to assume that Black and other racialized minorities find it hard, in situations where they experience racist behaviours, to decide whether or not to confront these issues. They wrestle with the fears of being labeled a troublemaker, being ostracized by their coworkers or losing their jobs. This assertion is supported by findings of Hagey et al (2001), research reporting that racialized nurses in the Greater Toronto Area who complained of race-based discrimination and harassment in the healthcare workplace, faced reprisals such as job losses.

This research, similarly, has consistently shown that racial identity significantly affects how people understand and experience their workplace environment. This finding concurs with the assertion by Broady (2001) that "...different others inhabit a very different and usually hostile workplace to familiar others" (¶. 5). This is not at all surprising given that notions of race remain salient in the broader society. And, of course, create barriers and challenges for racialized people that are notably different from those experienced by Whites. Experiences such as these are fraught with anxiety due to the systems of oppression encountered on a day-to-day basis. Broady (2001) further contends that for different 'Others', "In every meeting and interaction they have to decide whether to confront and challenge, 'just let it slide', report or educate, and do their job as well as everyone else who doesn't face these demands because they're 'familiar' " (¶. 5).

Differential Treatment and Biases Related To Leadership

Arguably, racialization in most organizational structures and processes tends to determine organizational fit and leadership suitability. Processes of racialization imbedded in most organizations influence how management competency and ability is constructed. Based on the ideology of White superiority, Whites are generally perceived as more suitable to assume leadership, and generally more accepted within organizational leadership structures than Blacks and other racialized people.

On the other hand, because of the racist ideology, Black women are typically viewed by the dominant culture in nursing as the antithesis to what it means to be a leader. The negative racialized identity assigned to Black women limits their employment opportunities for leadership positions. Hence, there are few racialized

nurses who have achieved leadership positions. I contend that the dominant construct of leadership negatively impacts the experiences of those few racialized nurses who achieve positions of leadership. This is a recurring theme in the workplace experiences of the sixteen Black nurses in leadership positions who were profiled in this study. Black women in leadership positions are particularly disadvantaged because their racial identity renders them highly visible and subject to excessive scrutiny and criticism. In fact, the literature consistently shows that Black managers received less favorable assessments of their leadership skills and abilities than White managers.

In this work, many of the participants' perceptions regarding experiences in the workplace are supported by the literature that suggests Blacks who achieve positions of authority and leadership "...often find themselves...in a continuous struggle to prevent becoming marginalized" (Fernando, 1996, p. 143). Notably, biases and prejudice towards racialized people make it difficult for them to establish authority and achieve success in the workplace hierarchy.

Strategies Towards a Non-Discriminatory Nurses' Workplace

Over the past several years, nurse researchers have increasingly focused on healthcare workplace environments in order to develop strategies for recruiting and retaining nurses, and improving their job satisfaction. Studies have consistently linked positive work environments to "productivity, job satisfaction, and retention and commitment of employees" (Snow, 2002, p. 397). From this viewpoint, it is reasonable to suggest that improving the work climate for racialized nurses is not only beneficial for

these nurses, but also for employers. Gone would be the charges of racism and other forms of unfair and discriminatory practices, and the potential for legal redress.

Unfortunately, nurse scholars have generally failed to acknowledge the prevalence of racist and discriminatory behaviours, and how they significantly impact racialized nurses' quality of work life. As Calliste (2000) states:

Black nurses' everyday experiences of racism reflect systemic racism in the workplace (for example, subjective recruitment, evaluation and promotion processes, as well as differential work assignments). Management practices and employment systems in these hospitals adversely affect Black nurses. The recruitment and promotion processes are often subjective and arbitrary and lead to discriminatory treatment of applicants (p. 160).

The study participants felt there was a need to ensure ethno-racial diversity within the various job categories. However, currently the CNO does not have a process or strategy in place for assessing the ethno-racial profile of nurses in Canada. Consequently, very little is known about the ethnic or racial composition of the nursing workforce. To address this concern, the study participants recommended that the CNO take the bold step of implementing a process for collecting racial and ethnic data on the nursing population.

Overwhelming concerns were also expressed about the under-representation of racial minority nurses in formal leadership positions. Many believed that the persistent disparities in the ethno-racial composition in nursing leadership demonstrated a continuing failure to address racialized nurses' unique perspectives and concerns around racialized power structures that deny them access to leadership positions.

The participants also talked at length about the need to eliminate racialized power structures that support continued subordination of racialized nursing leaders, in spite of their professional status and accomplishments. Ironically, there is a commonly held

belief, although inaccurate, that educated Blacks and other racialized individuals in professional jobs are less likely to experience workplace racism and discrimination than individuals who are less educated and in non-professional jobs. The findings of the current research clearly showed that attaining advanced levels of education and “professional” job status did not eliminate or reduce racialized individuals’ experiences of racism and discrimination in the workplace.

I suggest that the critical questions for nurse managers may actually be: What can I gain and what can I do to better existing conditions?

In order to minimize reprisals for resisting and to achieve institutional and systemic change, while at the same time addressing the politics of everyday racism and sexism, racialized minority nurses must take political action. They must unite and organize a strong association, as well as actively participate and get elected to the executive of their unions, professional associations...and their licensing bodies...where they could influence policy. Moreover, nurses must form meaningful coalitions and networks at the local, national and international levels with other anti-oppression movements in nursing, as well as in other institutions (such as universities and colleges) and workplaces. We cannot eliminate racism, sexism and other interlocking systems of social oppression in the healthcare system, without simultaneously combating them in education and transforming the social and economic institutions of capitalist society (Calliste, 2000, p. 163).

Summary

Although many Canadian healthcare organizations have adopted anti-racism and equal opportunity employment policies to prohibit various forms of discrimination, growing evidence suggests that these policies have done very little to improve racialized nurses’ quality of working life (Modibo, 2004), and that racism is all too often the norm.

There is ample evidence that Black and other racialized female nurses continue to encounter barriers, to varying degrees, during their careers. Healthcare facilities must recognize this, accept their complicity in perpetuating inequities, dispense with excuses

and adopt concerted approaches designed to eliminate racially constructed impediments.

These approaches must go beyond “lip service” to benefit the day-to-day lived experiences of racialized workers.

CHAPTER SEVEN

SUMMARY AND CONCLUSIONS

*Cowardice asks the question – is it safe?
Expediency asks the question – is it politic?
Vanity asks the question – is it popular?
But conscience asks the question – is it right?
And there comes a time when one must take a position that is
neither safe, nor politic, nor popular; but one must take it because
it is right.*

(Dr. Martin Luther King, Jr., 1968).

Introduction

The current study provided a forum for sixteen nurse leader participants to speak about Black women's issues in ways that were quite the opposite of what typically occurs within dominant discourses. In the context of the current study, the participants' experiences of racism and discrimination reflect the everyday realities of many racialized Canadian nurses.

By applying black feminist and integrative antiracism perspectives, I was able to generate knowledge from the stories and narratives that exposed the marginalization, problematization, and containment all too often typical of the experiences of these nurse leaders. Through the participants' narratives, we gain valuable insight into the devastating effects of everyday racism and, most importantly, the little that has been done on an organizational level to address this issue. The themes and sub-themes of this thesis were drawn from the women's stories. Through their responses to directly focused as well as follow-up questions, the study participants' perceptions were revealed in their narratives...expressions of self-doubt, reluctance to challenge discriminatory behaviour,

lack of will to even consider promotion and a general belief that change must begin with the organization itself, if equitable treatment is to become the status quo.

Qualitative Methodological Approach

The qualitative phenomenological approach utilized for this study focused on the workplace experiences of Black female nursing managers, revealing the human, subjective side. The ways in which these women have been and are relegated to the sidelines, whether in meetings, internal relationships with colleagues or at social gatherings outside of work, were brought to the fore. Some participants even spoke of racist encounters at the bedside, with White patients who brought their biases into the healthcare setting, using derogatory utterances that unquestionably smacked of preconditioned racist mindsets.

The qualitative approach was essential to seeing these women not as numbers or isolated entities, but as Black women who struggle against and often overcome barriers, despite an array of challenges.

Black Feminist Theorizing

It is important to restate that in the context of black feminist theorizing, Black women have a politics of resilience. It is also noteworthy that one of the main objectives of black feminism is to foster a commitment to social justice and liberation from the various forms of social oppression, including racism, sexism and classism (Collins, 1990). She also suggests another important feature of “Black feminist thought is its insistence that both the changed consciousness of individuals and the social

transformation of political and economic institutions... [are key elements] for social change" (p. 221).

Contrary to popular opinion amongst Whites, for decades Black women have individually and collectively engaged in resistance against major systems of oppression (Collins, 1990). Small (1999) points out the fact that Black women have been and continues to be at the core of all forms of resistance, and are generally in the majority of resistance movements. According to Collins (2000), from a black feminist perspective, Black women are not victims without individual agency, but self-defined and self-reliant individuals who are confronting race, class and gender oppression. In truth, Black women desire and continue to fight for full liberation and equality in a White dominant society.

hooks (2001) writes that for the most part, Black women changed in consciousness and their empowerment came about because of their lived experiences with racism and various other forms of oppression. Arguably, Black women have played and continue to play a significant role in advancing their own political empowerment.

Black women are now speaking for themselves, and challenging dominant Eurocentric epistemologies that misrepresent their lived experiences. A number of the women mentioned in their interviews that participating in this research study expanded their perspectives on their experiences. In the participants' words, as they articulated their feelings and experiences, they became more aware of racism and how the notion of difference based on racial identity played a key role in their day-to-day experiences.

Intersectionality of Race, Gender and Class

As discussed earlier in this work, scholars such as Browne & Misra (2003) have made the point that sometimes it's not only about race. For Black women in the workplace, it's hardly ever 'only' about race. It's about the combination of race, gender and class, and how the intersectionality of these two or three factors influences the work lives of Black females.

This work began with a desire for a better understanding of the work experiences of Black female nurse leaders in the Greater Toronto Area. In particular, I wanted to find out how notions of difference related to race impacted their experiences.

Previous studies on Black female nurses have generally found that they faced numerous challenges in their career advancement due to racism. But as authors such as Riley (2004) have explained, the three factors of race, gender and class cannot be viewed in isolation when it comes to the subordination of Black women, because of the 'simultaneous and compounding relationships' between these factors...in other words, the intersectionality.

One of the unfortunate long-perpetrated myths about Black women is that they are less intelligent than Whites. One of the unfortunate realities is that, due to a long history of marginalization, they often hold lower socioeconomic status. Power is mediated by notions of race, class, gender etc. Thus we see the intersectionality of the three factors, and the resultant power imbalances, in the painful experiences related by some of the study participants...stories of being discouraged from pursuing higher education by White bosses or being mistaken for housekeeping staff by White colleagues.

This examination of the complexities and nuances of race and its impact on the work experiences of Black Canadian nurse leaders across the Metropolitan Toronto area is a significant addition to the limited body of research literature about racism in nursing.

The Findings

In this study, as in others on racialized nurses, the participants expressed frustrations about the negative differential treatment they encountered daily in their work environments. Dei et al (2004) assert that, “As a socially constructed phenomenon, racism serves to position individuals and groups into different social locations -- locations that are based on access to privilege and power” (p. 17). In the context of the current study, it is not surprising that the participants perceived that the treatment they received was inferior to their White counterparts because of the “dichotomized constructions of Black and White women” (Bell & Nkomo, 2001, p. 236).

Job dissatisfaction among Black female nurse leaders is clearly related to their everyday experiences of racism and discrimination. In looking at the results of this study, it is important to keep in mind that race has a significant role to play in the power relation between Black and White women. Because of historical racial/ethnic inequities, an unequal power relationship exists between Whites and Blacks in contemporary societies. The experiences of the study participants in the workplace illustrate this unequal power relationship between Black and White women, and contrast the subordination of Black women with the privilege and dominance of their White counterparts.

Based on this study, it would appear that senior nursing leaders across the Greater Toronto Area, most of who are White Anglo-Saxon women, have often turned a blind eye to the problems faced by their Black colleagues. Either that or they are unwilling to fully engage resistance strategies to address racialized nurses' concerns related to systemic discrimination and racism in their working environments. Many nursing and healthcare leaders do indeed have opinions about what needs to be done. But there seems to be a general avoidance of taking action. Perhaps it's for fear of inculcating individual and joint strategic approaches of resistance across a wider workplace arena; something that might result in racialized members of the workforce challenging White hegemonic practices with confidence and without equivocation.

There were frequent mentions in the interviews that bias and prejudice based on race made it difficult for many of the participants to establish their authority as nurse leaders. This view is supported by Moses (as cited in Grimes, 2005) who states, "In some instances, women of color who land positional power are often 'tokens' who have title but no real...power within the organization to make things happen" (p. 3). Additionally, some mentioned they are denied the same levels of respect and creditability afforded to White nurse leaders.

It is also noteworthy that although a number of participants raised the issue of being motivated to work harder to avoid negative criticism, others said they are not influenced by the opinions of others. Regardless of their positional reactions or attitudes, none of the nurse managers changed how they performed their duties. As Gwen, one of the women in the study said, "I am very conscious that I could be critiqued differently

despite how good a job I do, that I would be evaluated on the fact that I am Black”
(11/5/05).

Societal realities, typified by subtle and blatant discriminatory behaviours, are part of the lived experiences of Black people in general, and as this study indicates, healthcare facilities reflect these societal realities. The narratives of the Black nurse leaders in this study were quite telling about their struggles to move beyond the margins to the mainstream of the nursing profession. In spite of the women’s educational accomplishments and administrative and supervisory positions, they spoke of their leadership often being undermined or subverted by practices of racism in the workplace environment. These problems have persisted because women from racial minorities are typically perceived as deficient and lacking in the skills and knowledge to perform competently in leadership roles.

It is my hope that the findings from this study will validate the need to challenge and change the status quo of racism and discrimination in the nursing profession. Through wide dissemination, this work can serve as a guide for reconstruction or, more accurately, construction of a platform of equitable treatment for racialized nurse leaders and racialized nurses in general.

Conclusions

The examination of the data collected supports several conclusions about the nurse leaders’ views of their workplace experiences. First, the nature of the environment in which many of these women work could be seen as hostile and pervasively negative. From the participants’ accounts, it is evident that they face challenges presented by

workplace racism. However, their frank responses to the research questions suggested to me a desire on their part to have their experiences brought to light, perhaps in the hope that awareness will lead to positive changes in working environments for racialized nurses.

I believe racialized nurse leaders must also 'reinvent' themselves; rather than continuing to think in terms of the abstract 'something must be done' locus to remove the barriers they face ('if wishes were horses...'), they need to become proactive and committed agents for constructive change. In fairness, the fact that these women participated in my research demonstrates their resolve to change the status quo by not remaining silent on issues of racism and other inequalities in the nursing profession. But disengaging from silence for the purposes of this study is or should be the first and not the final step.

Under Canadian law, it is illegal to discriminate against anyone on various grounds including race, gender and class. However, the study participants' stories are proof that many healthcare organizations in the Great Toronto Area fail to ensure such practices do not affect racialized minority employees, including Black nurse leaders. The current empirical findings confirmed earlier research that suggested racist ideological thinking in many healthcare institutions in Canada has created a destructive division between Black and White nurses that hinders the possibility of cohesiveness in the profession. This study has clearly shown there is a need to reshape a healthcare industry that perpetuates adverse workplace challenges and barriers that negatively impact the day-to-day work experiences of nurses from racialized minority backgrounds.

What is also clear from the literature reviewed is that the study participants' experiences are not unlike the experiences of racialized minorities in other professions such as education (Thomas & Hollenshead, 2001; Samuel, 2005). The conclusion drawn is that anti-Black racism has no limitations or boundaries, and is arguably pervasive within Canada's mainstream institutions and "tantamount to individual and systemic forms of Black oppression and powerlessness" (Benjamin, 2003, p. 9).

Undeniable Albeit Painful Progress

There is no easy walk to freedom anywhere, and many of us will have to pass through the valley of the shadow of death again and again before we reach the mountaintop of our desires.

(Nelson Mandela, 1953)

Although not in any way to invalidate the experiences of discrimination and racism of the study participants, it must be acknowledged that race relations have improved in the nursing profession, particularly since the publications of scholars like Head (1985) and Calliste (1993, 1996, 2000). The racism experienced by the nurse leader participants in this study is painfully real, but the fact that is one indication that opportunities for racialized people to ascend to positions of authority traditionally held by Whites do finally exist and are becoming more prevalent. Hence, there has been a steady increase of minority nurses in positions of leadership.

Other examples of members of minority groups occupying various important leadership positions in other walks of life can be cited; e.g. in education a number of noted scholars occupy senior faculty positions in Canadian universities. Not to mention, of course, the event that so many people of all races never thought they would live to see

-- the election of the first racialized President of the United States of America, Barack Obama. To quote Nelson Mandela again: "It always seems impossible until it's done."

The victories of the study's nurse leaders, and those of all racialized people, have been hard won and are incomplete. Injustice continues, and it's difficult for someone to be mindful of what Martin Luther King Jr. (1967) called "the fierce urgency of now" when they are struggling just to get through their day. But the perseverance and resilience that brought racialized people this far will sustain them, and the victories, large and small, will empower them, toward the ultimate goal of a colour-blind workplace and society. As Barack Obama (2008) said in his address on Super Tuesday in Chicago: "Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek."

Study Limitations

The present study has a few limitations that need acknowledgment. The first apparent limitation that must be identified is the possibility of selection bias, because the participants are self-selected rather than randomly selected.

As well, all of the women interviewed are from African and Caribbean backgrounds, and have been in Canada for a number of years. Understandably, there may be findings in this study that are not relevant for other Black female nurse leaders, who may have different perceptions about their experiences in the workplace.

While a key finding of my study is that Black nurse leaders are subjected to racism and other forms of discrimination in their day-to-day experiences in Canadian healthcare workplaces, a potential limitation of the research is the relatively small

number in the sample (n=16). Therefore, the findings cannot be generalized to the total population of Black nurse managers in the Metropolitan Toronto Area and beyond. It should be noted that many authors argue a small sample size is acceptable in qualitative research, because the aim is to provide rich descriptive data and not the numerical correlations associated with the quantitative research approach.

Another limitation of this study was that the participants were recruited only from the Greater Toronto Area. Future studies should recruit from a wider geographical area, and include not just Blacks, but other racialized nurses as well. This might generate a larger and more diverse sample and, possibly, different findings.

Not all the data collected in this research was included in the analysis. Some women were concerned that they could be identified by their statements. Finally, another potential weakness of the research could be bias inadvertently introduced by me in the collection and analysis of the data. Despite these limitations, this work expands the existing body of research on racism in the profession of nursing.

The Future

Dei (2000) asserts that one of the premises of antiracism is that racial minorities cannot be presented primarily as victims who are helpless and subordinate to the dominant. From his perspective, marginalized racialized people have histories of resistance against hegemonic racist practices in society. In fact, people of African descent have been mobilizing collective resistance since the early days of slavery -- a practice that continues to the present day. Small (1999) argues that Black people have resisted many obstacles confronting them through "individual and collective strategies,

many of which are articulated around the organizations and institutions of the Black community...” (p. 57).

Black women refuse to be silent about their experiences of racism; they want their voices to be heard and their issues to be addressed. Consistent with this view, it is notable that the Black women in the current study have chosen to enact their individual agency through conscious acts of resistance against discrimination and oppression in their places of employment, although perhaps not in ways that are blatantly obvious. These Black female nurse leaders have chosen not to embrace a ‘victim mentality’, but rather have come together to break the cycle of fear and silence, and to give voice to issues and concerns that directly affect racialized nurses’ work lives. It is significant that the Black women in the current study have spoken about the injustices and inequalities they experience in the workplace because of their racial identity

This research study aims to identify suitable antiracism strategies for change in the current work environments of racial minority nurses in the Greater Toronto Area and beyond. Because this research takes an antiracism stance, the saliency of race was maintained at the forefront of the analysis and interpretation of the empirical data collected from the study participants. Based on the analysis of the study participants’ narratives, I conclude there is an urgent need to address the racial discord and gross inequality that adversely affect the work lives of many racialized minority nurses.

Most importantly, I argue that social justice and antiracism change in the workplace environment should not be the sole responsibility of racialized minorities, but rather Whites should assume an even greater responsibility to challenge racism and discrimination, because they have played an active role in perpetuating racism in society

for their own power and privilege. As Dei (1996) points out, a critical antiracism praxis is necessary to effect antiracism social change. Dei (1996) further asserts that, “the task of integrative anti-racism is to unravel...interlocking systems of oppression in order to be able to intellectually articulate and engage in meaningful and progressive political action to address social injustice and oppression” (p. 62).

Implementation and support of antiracism initiatives and practices would mean the loss of privileges related to the notion of whiteness. In particular, Dei (2000) points out that antiracism practices destabilize whiteness, by challenging claims of privilege and normalcy and, in many ways, “...targets claims to innocence” (p. 28). According to Dei (2000), antiracism education is transformative learning that supports social change. He asserts that antiracism education is different from multicultural and diversity training, both of which are ineffective in dealing with racism. Antiracism education is a strategy aimed at changing racist ideologies and practices in institutional structures (Dei, 2000). He further mentions that antiracism challenges “the marginalization of certain voices...and the devaluation of the knowledge...of subordinate...groups” (p. 34). Additionally, Dei argues that antiracism challenges the meaning of “valid” knowledge, and questions how this knowledge is produced and disseminated (p.34).

The knowledge garnered from the participants’ perspectives on how race has shaped their workplace experiences can be used to articulate the need for change in existing healthcare environments. Nurses, individually and collectively, professional nurses’ associations and colleges, and healthcare employers can take advantage of this resource to engage in political action to change the healthcare workplace.

Further research is needed to investigate how race influences the experiences of nurses of colour, not just Blacks, in the healthcare workplace. Black and other racialized nurses enrolled in graduate studies should consider conducting research aimed at giving voice to racialized minority nurses. To this end, research funding agencies and professional nursing associations and colleges should reach out to racialized graduate nursing students, and offer funding and fellowships to students who are interested in doing research on the impact of racism.

As well, because there is limited Canadian nursing research that focuses on racialized minority nurses in leadership positions, my study being one of the first, it is reasonable to suggest that further research is also needed to examine issues of race and racism within nursing leadership.

Although the women in the study encountered numerous challenges in their places of employment, it is noteworthy that they also demonstrated resilience and a commitment to work towards the elimination of racism in the nursing workforce. They refuse to be victims of their circumstances, and have found ways of effectively dealing with the various forms of racism and discrimination they experience on a day-to-day basis.

Stereotypes of Black women are not for them...they are too busy striving to achieve academic and professional excellence, as evidenced by their accomplishments. Although very much conscious of their circumstances, they live life to the fullest, professionally and socially. Several of the study participants excel outside of their workplaces as public speakers, community activists, etc.

The study participants are also proactive. They have taken the lead on the major undertaking of educating others about racism in the profession. Being at the cusp of their careers, these women are mentoring newcomers to the nursing profession to support them in achieving their career goals. But most of all, in spite of their subordinate status and their daily struggles against racism in the workplace, these Black female nurse leaders have successfully maintained their personal and professional integrities.

It is my opinion that the results of this study have a number of implications for the nursing profession, particularly as a starting point for senior nursing leaders in Canada to focus their attention on improving the quality of the work lives of Black and other racialized nurses. It is my belief that, in order to sustain the nursing profession in Canada, nurse leaders have to look beyond the rhetoric of inclusiveness, and begin to accept the painful reality that racism remains imbedded in Canada's healthcare system and institutions. Additionally, nursing leaders must take full responsibility and immediate and drastic action to deal with the racism and inequalities faced by racialized nurses in the workplace.

No matter how much we may want to believe that we live in a colour-blind society, it has become impossible for Canadians, whatever their racial backgrounds, to ignore the presence of racism in our public institutions. The narratives of those whose lives are affected by racism daily tell of a bias that is devastating to their physical and emotional wellbeing. Their previously untold stories reveal the various forms of social oppression extant in our healthcare institutions. These truths should be documented in the annals of Canadian nursing history.

It is my fervent hope that this research will give a voice to Black colleagues, and that the findings of this study will be paid special attention in nursing and healthcare milieus, so that they might serve to initiate changes that will improve the quality of work life for Black and other racialized nurses.

This research project is both relevant and timely because it seeks to initiate a dialogue for change, and to offer valid strategies for increasing ethno-racial representation at all levels of nursing as we plan for the future care of increasingly diverse patient populations.

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APPENDIX A

Ethics Protocol

Research Title: Themes of Racial Discrimination in the Experience of Black Female Nurse Managers

Principle Investigator: Paulette Marcia Stewart
 Faculty Supervisor: Dr. George J. Sefa Dei

Department: Department of Sociology and Equity Studies in Education

1. Background, Purpose and Objectives

For decades, Canada has taken pride in being one of the most multicultural contemporary societies in the world, and a leader in human rights (Moore, 2001). Within the context of a multicultural society, the notion of diversity within Canadian workplaces has received much attention in recent years. However, despite claims of inclusiveness and equity for all Canadians, it is widely acknowledged that, even with anti-discrimination legislation in effect for decades, various forms of discrimination persist in many Canadian workplaces (Agocs et al, 2001).

In addition, it concerns me that the Canadian nursing workforce lacks the racial and ethnic diversity of the population that it serves. I am further perplexed that, in the current healthcare environment, there are few nurses of colour, particularly Blacks, in leadership positions. A growing body of literature confirms that racial minorities are under-represented in health services management, and there is a constant disparity in the job satisfaction of managers of colour and White managers (Bessent & Fleming, 2003; Dreachslin, Sprainer & Jimpson, 2002; Schmieding, 2000). The complexities of these issues necessitates critical examination because according to Schmieding (2000), “the presence or absence of minority nurses in...leadership positions influences organizational goals and priorities, and conveys a positive or negative visual image to persons from minority groups who aspire to enter the profession” (p. 120). Furthermore, Bessent & Fleming (2003) noted that “minority nurse leaders are necessary to effectively meet the needs of a society in nursing” (p. 258).

I propose to conduct a qualitative study to examine how race constructs the how the intersectionality of race, gender and class construct the experiences of Black female Nurse Managers in Canada. Entitled, Themes of Racial Discrimination in the Experiences of Black Female Nurse Managers, this study will examine the following questions:

- I. How does race impact the day-to-day experiences of Canadian Black women as Nurse Managers?
- II. How does race determine the established nature of leadership expectations?
- III. What, if any, are the key barriers and challenges encountered from the perspectives of Black female Nurse Managers?
- IV. What resistance strategies and coping skills do Black nurse leaders use to maintain their personal and professional integrity in the workplace?
- V. What strategies are needed to diversify the Canadian nursing workforce?

The main learning objectives of this project are: a) to highlight the challenges Afro-Canadian/Caribbean women face in their roles as nurse managers; b) to explore how minorities understand their own oppression; c) to explore how these women engage in political resistance; d) to identify strategies to improve the work experiences of female nurse leaders; and e) to produce knowledge about the work lives of Black nurse managers

2. Research Methodology

This study uses a qualitative approach to explore how Black female nurse managers perceive and experience leadership in the workplace. A qualitative method was chosen to allow in-depth exploration of the research issues, and to enable the researcher to describe in a meaningful way the distinctiveness of the participants' opinions, experiences and feelings without changing the phenomenon being examined (Hancock, 1998; Hilton, 2002; Miller & Jezewski, 2001). The use of a qualitative approach in this study is appropriate because I wanted to produce detailed data rooted in context. For these reasons, qualitative methods such as a questionnaire or focus group would be limiting to the study.

3. Participants Sample Size

I have chosen to study sixteen (16) Black female nurse managers from various healthcare facilities in the Metropolitan Toronto Area to share their experiences in this descriptive qualitative study. The study will select women of African descent who were born in Africa, the Caribbean region or Canada, and who are currently employed as nurse managers and have been in this role for more than six months. The study will recruit women of different age and cultural background who speak English and who have completed their Registered Nurse education in a variety of countries including Canada. (*Please see APPENDIX B: Information Letter for Research Participants*). The diversity of the sample is intended to generate a wide range of perspectives on how these variables influence these women's opinions of their experiences.

Given that this is a qualitative study, the sample size is intentionally small. In addition, as the numbers of African Canadian/Caribbean Nurse Managers are considerably limited,

it may be difficult to acquire a large number of participants who meet the criteria. The small sample size in qualitative research is supported by Russell & Gregory (2003) because it enables the researcher to "...more fully explore a broader range of participants' experiences" (p. 38). As Cuadraz & Uttal (1999) say, "...the power of small samples to theorize socially significant issues should not be overlooked" (p. 166). These authors also posited that large samples add time and effort to the research process "without strengthening the inferential representative or social validity of the finding" (p. 166). In regards to the study, a smaller sample size will enable the researcher to gain a more personal understanding of the respondents' experiences.

A pre-interview questionnaire will be provided to collect biographical and demographic information to establish a profile of each woman and an overall profile of the participants. (Please see APPENDIX F: Biographical and Demographic Data Form). This will be followed with an audio-taped individual interview with each participant. The interviews consist of semi-structured questions designed to probe for work experiences. (Please see APPENDIX G: Interview Guide).

Detailed summary notes of the interviews will be taken during the interviews with the consent of the participants to augment the audio-taped data. Each participant will be invited to review a copy of the transcript of their interview for further comments and clarification, if she wishes to do so. The intent is to interview each manager once, but to ask for permission to do a follow-up interview should further clarification be necessary. Each interview will last one to one and a half hours and will be conducted over a two-month period beginning in April 2005.

4. Data Analysis

My particular interest in this study is to gather information about and conduct in-depth analysis into what Black female nurse managers say about their work experiences. As such, the research data will be analyzed with the use of qualitative techniques. Interview data will be transcribed verbatim to create the text for thematic analysis. The data will be analyzed and categorized into themes common to all participants. Themes that are common to the research focus may include: 1) definitions of leadership; 2) views on leadership; 3) power relations; 4) racism and other forms of discrimination; 5) personal challenges affecting performance; 6) vulnerability and stigmatization; 7) resistance strategies; and 8) points of contentions and conflictual analyses. After the preliminary thematic analysis, the participants will be asked to review the transcript and determine if the categorized themes present an accurate interpretation of their experiences. Individual perspectives of all participants will be analyzed for similarities and differences.

5. Recruitment

Study participants will be recruited through various means from different healthcare facilities such as hospitals, long-term care facilities, public health units and community-based clinics. Letters explaining the purpose of the study will be sent to Human Resource Departments in the aforementioned healthcare facilities in Southern Ontario to

request assistance in recruiting participants. (Please see APPENDIX D: Information Letter to Human Resource Departments). A snowball technique will also be used to recruit additional participants because it provides a means of accessing respondents where they are few in number (Atkinson & Flint, 2001). Nursing colleagues and friends will be asked to identify potential recruits. If subjects are not recruited through the aforementioned approaches, the study will be advertised in various ethnic newspapers that serve the Afro-Canadian/Caribbean community. (Please see APPENDIX E: Recruiting Flyer for Newspaper Advertisement).

6. Risk and Benefits

There are no physical risks to the participants from participating in the study. Because of the sensitive nature of the research topic, it is quite possible that the participants may be uncomfortable discussing issues such as racism and oppression. While there is the possibility of bringing up painful emotions, each participant has a thorough understanding that she can refuse to answer any question she chooses. I will conduct the interviews with respect for the sensitive nature of the topic and the need to ensure confidentiality of the participants' stories. In addition, I will have a list of crisis phone numbers for the participants to access, should this be necessary.

7. Privacy and Confidentiality

Oka & Shaw (2000) emphasize that "...confidentiality is a vital requirement for credible research" (p. 16). In this study, the utmost diligence will be taken to maintain privacy and confidentiality of the participants and to protect their personal data against unauthorized or accidental access and or disclosure. Given the sensitive nature of the research topic, individual interviews will be conducted at locations carefully selected to ensure maximum privacy. To ensure confidentiality and anonymity, numbers and pseudonyms will be assigned to the participants and their employment institutions to ensure information cannot be traced to any of the participants and their employers. All confidential information including notes, tape recordings and drafts of the study will be secured in a locked file cabinet in my home office that is accessible only to me. I intend to store the transcribed data on my home computer in password-protected files as an added level of security to prevent unauthorized access to computer stored data. However, it is important to note that data will not be stored with individual and institution identifiers. In addition, copies of confidential information will be kept to the minimum and emails will not be used to send confidential information to the participants. Similarly, identifiable confidential information will not be disclosed by telephone or by FAX. In reporting the data, participants' identifiers will be excluded from any documentation pertaining to the study that will become public (Hassouneh-Phillips & Beckett, 2003). Institutions will not be referred to by specific names, but by generic terms, such as 'the hospital' or 'health unit'. In presenting the research findings, individual quotes may be used, but they will be recognizable only to the participants who contributed them. Lastly, original tapes and transcripts will be destroyed within five years of the completion of the study.

8. Compensation

No monetary compensation will be provided to the participants. It is likely that specific provisions for child care and transportation may have to be negotiated in some circumstances. However, I plan to arrange interviews at times and locations that are convenient for the participants.

9. Conflict of Interest

To my knowledge, there is no potential for the development of any conflict of interest. However, participants will not be recruited from the same healthcare institution in which I am employed.

10. Informed Consent Process: Please see Appendix C: Letter of Consent

11. Scholarly review: N/A

12. Additional ethics reviews: N/A

13. Contracts: N/A

14. Clinical trials: N/A

APPENDIX B

Information Letter for Research Participants

Date:

Dear prospective participant:

My name is Paulette Stewart, and I am a doctoral student at Ontario Institute of Education (OISE) at the University of Toronto in the department of Sociology and Equity Studies in Education. I am currently conducting a research study that explores the experiences of Black female Nurse Managers in Southern Ontario for my thesis. The study is designed to examine the ways in which these women's experiences are influenced by intersectionality of race, gender and class as categories constructed within the Western context. More specifically, one of the major aims of the study is to explore how hierarchies based on difference, particularly those related to race, gender and class, are constructed, maintained and contested by Black women in nursing leadership positions.

To date, Canadian nursing literature has given little attention to Black nurses in leadership positions. However, there is a growing body of literature on racial minority nurses that shows Blacks and other racial minority nurses encounter barriers within the workplace that negatively affect their work experiences and hinder their careers from developing to the fullest potential.

I intend to interview sixteen (16) Black female Nurse Managers from various healthcare facilities in the Metropolitan Toronto to share their experiences in this descriptive study. The criteria for participation in the study include being a Black female of Afro-Caribbean decent, English speaking and currently employed as a Nurse Manager. The study will hopefully provide valuable information on the experiences of Black female nurse managers in Ontario. The research could contribute to the current deficit of knowledge about Black nurses in Canada. The findings of the study will be used to inform nursing administrators about workplace issues that impact the work lives of racialized nurses and identify effective strategies to improve the work experiences for Black and other racialized nurses.

Your participation in the study is voluntary. If you agree to participate in the study you will receive a copy of the interview questions in advance. You will be asked to sign a consent form before the interview to ensure that you understand what you are agreeing to. A copy of the consent form, as well as the information letter will be given to you. You will be asked to complete a pre-interview questionnaire to collect biographical and demographic information. This will be followed by one face-to-face audio-taped interview about your experiences in your workplace. The interview will be conducted at a mutually convenient time and location that is conducive to thoughtful exchange and will be approximately one to one and a half hours in length. During the interview, you may

request that I pause or stop the recording at any time. It is important to note that you have the option to withdraw from the study at any point of the process.

Because of the personal nature of your experiences, you may reflect on unpleasant memories during the interview. If you begin to feel uncomfortable you may stop participation, either temporarily or permanently. The interviewer will have a list of phone numbers that you can be referred to if you feel you need support.

Although there are no known direct benefits to participation, nevertheless, your concerns are valued and I consider them a welcome contribution to research on nursing in Canada. In addition, the study provides an opportunity for you to gain insight into your own experiences.

The study will be undertaken with the utmost respect for confidentiality and anonymity. To ensure confidentiality and anonymity, you will be allocated a number and a pseudonym that will be used to ensure that the interviews cannot be traced to any specific individual participant. The same applies to the healthcare organization at which you are employed. Your name as well as your employer will be protected. All the information obtained during the interview will be kept in locked filing cabinet and will be analyzed only after they are transcribed into separate notes that will be reviewed only with my thesis committee. After analysis, I will document the findings in my thesis and seek their publication in a number of articles in research and professional journals. Audio-tapes, field notes and all confidential information will be destroyed within seven years after the completion of the study. It is important to note that Dr. Dei or the other professors on my research committee will not be privy to your identity. Dr. George Dei, at the OISE, can be reached at (416) 923-6641 ext. 2513 or by e-mail at gdei@oise.utoronto.ca should you have any questions about the supervision of my work.

After the interview is completed, you will be provided a copy of your transcript for review to make certain that your words have been accurately recorded. You will be asked to participate in the analysis process by providing feedback on how the data you provided is interpreted. Results from this study will be available to participants if desired. You may also decide to add or qualify your statements after the interview is completed. You can choose to withdraw specific comments for up to 2 weeks following the interview and can do so by calling me at 416- 631-9981 and leaving a message.

If you are interested in participating in this study, or have any questions about the research that have not been addressed in this information letter, please contact Paulette Stewart at (416) 631-9981 or by e-mail at pmstewart@mtsinai.on.ca and leave a message with your name and phone number.

Thanks for your time and interest in my research and I look forward to hearing from you in the near future.

Sincerely,
Paulette Stewart, OISE/UT

APPENDIX C



ONTARIO INSTITUTE FOR
STUDIES IN EDUCATION
OF THE UNIVERSITY
OF TORONTO
252 Bloor Street West
Toronto, Ontario
Canada M5S 1V6
Telephone: (416) 923-6641

Letter of Consent

RE: Research Study – Through the Lens of Race and Gender: The Experiences of Black Female Nurse Managers, by Paulette Stewart.

I _____ (please print name) have read the information letter describing the study that you are planning to conduct and have had the opportunity to ask questions about the study. I understand that my participation is voluntary and I can withdraw at anytime. All my questions about the study have been answered to my satisfaction and I consent to participate in the study.

Participant's Signature

Date

APPENDIX D

Information Letter to Human Resource Departments.

Date _____

Dear _____

I am a student at the Ontario Institute for Studies in Education(OISE) of the University of Toronto currently working on my Ph.D. thesis entitled: "Through the Lens of Race, Gender and Class: The Experiences of Black Female Nurse Managers". I am interested in examining how issues of race, gender and class impact the day-to-day experiences of Black female Nurse Managers in the work place environment. The criteria for participation in the study include being a Black female of Afro-Canadian/Caribbean decent, English speaking and currently employed as a Nurse Manager.

This letter is a formal request for administrative approval to approach individuals at your institution to participate in the study. The study involves an individual interview that will last for 1-1 ½ hours long at a mutually agreed location and time.

I am extremely grateful for your assistance and would be glad to answer any questions you may have. My thesis supervisor, Dr. George Dei, at the OISE, can be reached at (416) 923-6641 ext. 2513 or by email at gdei@oise.utoronto.ca should you have any questions about the supervision of my work.

I have enclosed an information sheet about the study that may be given to individuals interested in the study.

I look forward to hearing from you in the near future.

Yours sincerely,

Paulette Stewart
77 Combe Avenue
Toronto, Ont. M3H 4J6
(416) 631-9981
E-mail: pmstewart@mtsinai.on.ca

APPENDIX E

Recruiting Flyer for Newspaper Advertisement

AFRO-CANADIAN/CARRIBBEAN NURSE MANAGERS NEEDED FOR STUDY

A Ph.D. student at the Ontario Institute of Education (OISE), University of Toronto, is seeking volunteers to participate in a research project investigating how race, gender and class affect the experiences of Black female nurse managers in healthcare institutions in Ontario. Participants must be Black, female of African/Caribbean decent and currently employed as a Nurse Manager in a healthcare institution.

The study requires one interview that may last 1-1 ½ hours. Participants will not be paid for participation.

If you might be interested in taking part or would like more information please call (416) 631-9981.

Principle Investigator: Paulette Stewart

APPENDIX F

Biographical and Demographic Data Form

Date: _____

Name: _____

Age: _____

Ethnicity: _____

Birth place: _____

Parents' birth places: _____

Highest Level of Education Attained and Place of Education: _____

Related Professional Activities: _____

Identity any Interruptions in your Career: _____

Other leadership positions you held in Canada and how many years you were in the position (s)? _____

Describe the responsibilities of your position: _____

APPENDIX G

Interview Guide

(This is a partial list of questions organized in themes)

I. Work Experiences and Oppression

1. Tell me about any experiences you might have had that made you wonder if you were being treated differently.
2. Are any of the difficulties and challenges you face in your position related to gender or race?
 - a) Gender and race?
3. How do you think your racial background affects your work experiences?
4. How do you think your gender identity affects your work experiences?
5. Have you experienced racism? Sexism? Other forms of discrimination?
6.
 - a) Can you describe what happened?
 - b) Can you describe how you felt?
 - c) How did it affect your work performance?
7. Have you thought about the reasons why the incident happened to you? What did you do about it?
8. Do you think your experiences are different to other racialized women in similar positions? If yes, please describe. If no, why not?
9. Give examples of your relationships with your co-workers, underlings, supervisors, physicians and patients.
10. What are your chances of further career advancement?
11. Have you received any mentorship and support in your position? Noticed others getting mentorship but not you? If so, please describe.
12. Do you have opportunities to mentor staff or support them?

13. Describe leadership in terms of your role as Nurse Leader.

- a) Describe any occasions where your identity as a Black woman may have been a plus or liability.

II. Resilience and Coping Strategies

14. Can you describe the strategies you have used in dealing with discrimination in the workplace?

15. Can you describe the strategies you have found effective in dealing with discrimination in the workplace?

16. Can you identify the strategies you would recommend to potential nurse leaders?

- a) Can you describe why you recommend the identified strategies?

17. Can you describe effective support systems available in the workplace?

III. Creating Healthy Workplaces

18. Reflecting on your experiences, what can employers do to create an inclusive and non-discriminatory workplace environment?

19. Do you think it is important to increase the numbers of Black and other racial minority nurses in leadership positions? If yes, please describe why. If no, why not?

20. Can you describe ways to increase the numbers of Black and other racial minority women in nursing leadership positions?

21. Does your workplace have any anti-harassment and anti-discrimination policies?

- a) If yes, do you feel these policies are effective?