NCPD Ethics Series
2.0 ANCC Contact Hours

Racial Discrimination in Patient Care—Preserving Relationships With Integrity

Donna M. Fahey, MSN, MFA, RN, CHPN, AHN-BC, CNL

The following case study describes what is known as the health care system's open secret of allowing a patient or family to refuse care from a clinician of another race. This article explores the ethical tension between autonomy, nonmaleficence, justice, and duty to treat as it relates to racism and the potential harm to clinicians, health care teams, and organizations. When racism is experienced within the clinical setting, clinician knowledge, organizational training, and moral character are essential for identifying and addressing it effectively. Racial discrimination and related mistreatment are not part of a responsive and proactive moral community. This article explores creative solutions that preserve patient-clinician relationships without sacrificing personal integrity when racism is encountered.

KEY WORDS
discrimination, ethics, hospice, palliative care, racism

Racism is prevalent in our society. It is ingrained in our culture and economy. Because health care settings are part of the larger society, they are vulnerable to racism. When patients and families seek care in hospitals, home care, and hospices, they bring their prejudice and bias. A common dilemma experienced in health care is dealing with patients or their families who request staff reassignment based on skin color, race, and ethnicity. Health care workers navigating these requests often reassign staff. With health care's focus on patient-centered care, patient preferences are important. However, are there limits? What effect do these decisions have on individuals, the health care team, and the overall landscape of racism?

Employees have the right to work in an environment free from discrimination. However, people of color working in health care experience discrimination from patients and their families, which is often ignored.[1] Individuals and organizations may not know what to do to not upset patients and families or fail to identify racial discrimination. Racism may be challenging for White individuals or those from a dominant race to decipher. Even a well-intended individual who considers himself/herself nonracist may perpetuate racism from a lack of awareness or implicit bias.

Nurses have personal and professional responsibility to address racism. Because all forms of racism are harmful to the clinician, the patient, and the organization, determining whether an action is racist is primary. Second, weighing the ethical tensions involved determines the right action. Third, nurse leaders need to advocate for creating policies and procedures to prepare all clinicians for racial dilemmas before they happen, when they happen, and after they happen.

CASE STUDY

It is the start of the night shift. After receiving a report from the previous certified home health aide (CHHA), Ax makes initial rounds on patients recently admitted to an inpatient hospice center. After introductions, the patient's daughter asks if she may privately speak to the nurse. The daughter explains to the charge nurse, Mic, that she does not want any dark- or brown-skinned clinicians caring for her mother. Mic explains that every aide working for the organization is equally skilled and that Ax is compassionate with many years of experience. The daughter appears distressed, and to avoid further upset, Mic agrees to her request. After leaving the room, Mic confides with the team, stating that the family does not want Ax caring for the patient. Mic does not share that this decision was based on skin color, but Ax knows that skin color is the real reason. With no other CHHA working, Mic assumes the patient's total care for the remainder of the shift. Mic reaches out to the clinical manager, Chris, in the morning to explain the situation and the decision to place a note within the electronic health record (EHR) to assign only White clinicians.

The clinical manager, Chris, speaks with CHHA, Ax, to evaluate the impact the encounter may have had. Ax tells the clinical manager that "you just have to put your feelings in your pocket" and "that's just who they are and how they are brought up."[2] During report, the day shift nurse reacts to the note Mic placed in the EHR to assign only White clinicians. After a quick reassignment, the day shift nurse states, "This cuts like a knife."[2] The clinical manager reaches out to

Donna M. Fahey, MSN, MFA, RN, CHPN, AHN-BC, CNL, is director of the Samaritan Institute for Education, Research & Innovation, Mt Laurel, New Jersey, and adjunct faculty within the Complementary & Integrative Health program at Drexel University, Philadelphia, Pennsylvania.

Address correspondence to Donna M. Fahey, MSN, MFA, RN, CHPN, AHN-BC, CNL, 3906 Church Road, Mount Laurel, NJ 08054 (dfahey@SamaritanNJ.org).

The author has no conflicts of interest to disclose.

Copyright © 2022 by The Hospice and Palliative Nurses Association. All rights reserved.

DOI: 10.1097/NJH.0000000000000910

the organization for support and receives little guidance to effectively balance the patient's interests, employee rights, and the duty to treat.[3] Later that evening, the patient experiences a dignified death, and the daughter writes a beautiful letter of thanks noting that the staff's professionalism and compassion were unprecedented.

LITERATURE REVIEW

Reports on Racism

The National Commission to Address Racism in Nursing (National Commission) defines racism as "assaults on the human spirit in the form of bias, prejudice, and an ideology of superiority that persistently cause moral suffering and perpetuate injustices and inequalities."[4(p1)] Racism is common in the workplace and may manifest as "microaggressions and bias, stereotype threat, disregards for positions, and institutional neglect."[5(p96)] Nurses, particularly nurses of color, are no exception to these experiences. Nurses experience more discriminatory interactions with their patients and families than any other member of the health care team.[6] According to 5623 nurses surveyed in October 2021, two-thirds (63%) experienced an act of racism in the workplace, by a peer (66%), a patient (63%), or a manager/supervisor (60%).[7] Black nurses and nursing assistants experience subtle and explicit racism affecting well-being and career trajectories across health care settings.[2] Nursing assistants "expressed having little to no recourse against their direct supervisor's actions or inactions"[2(p314)] and are vulnerable to harm because of the subservient nature of their profession.[6] These encounters stress the health care environment and further threaten well-being.[2]

Person(s) Harmed

Clinicians experience physical symptoms of stress, such as anxiety, burnout, depression, insomnia, and substance abuse, in response to racism.[2,8] "Being the subject of a discriminatory gesture represents a unique source of trauma, particularly because it derives its destructive power from its occurrence in a wider contemporary context of pervasive racism, White supremacy, and the historical context of slavery."[9(p5)] The discriminatory gesture is a term used for what may be considered a minor instance of bias or discrimination. Caution is needed in classifying any action as minor outside the experience of the actual event because the proportion of harm can be hard to understand from the outside.[9] Nonetheless, even this minor action can lead to posttraumatic reactions because of its fluidity and pervasiveness as an interpersonal event.[9] Expressions of a patient's racial preferences may be regarded as a discriminatory gesture and cause harm. They are described as painful and degrading and actions that cumulatively contribute to worsening disparity for minority health care workers and high organizational attrition.[8,10]

Institutional Responses

The harmful effects of racial discrimination can extend beyond the target to affect third parties.[11] This ambient effect on those who witness or hear about the event is personally harmful and contributes to low organizational commitment.[11] In addition, employee engagement is threatened when organizations fail to hear and address these experiences. In the National Commission[4] survey, 57% of the nurses challenged racist treatment, and more than half (64%) said their efforts resulted in no change.[7] In addition, nurses feel left to fend for themselves when faced with racial discrimination, especially from patients and their families. Health care agencies may not deliberately use a laissez-faire leadership approach; however, many expect nurses to solve problems independently.[12] Continuing to practice within ambiguity regarding the right thing to do in an ethical dilemma damages the work environment.[8] It contributes to decreased job satisfaction and increased moral distress and burnout.[12]

Legal Considerations

Within the past decade, lawsuits have appeared across the nation regarding racial discrimination, and unfair treatment of a clinician prevented from doing their job based on the color of their skin.[6,13,14] Race-based reassignments violate the employee's right to work free of discrimination based on the Civil Rights Act of 1964 Title VII.[10] Workplace disparity escalated in 2020 when minority populations and clinicians were disproportionately threatened by the COVID-19 pandemic,[5] reminding leaders that race-related inequity remains a problem. Diversifying the health care workforce is a promising strategy to increase access and equity and decrease health disparities. As more organizations diversify their workforce and populations served, racial tension and discriminatory interactions between patients and nurses may increase. Policies and procedures that improve racial climates within an organization are critical to reduce the organizational risk of hostile work environments and racial discrimination claims.[5]

ETHICAL PRINCIPLES

Discussion on Racism

Determining whether the reassignment of staff is racist is complicated. Racism is a social construct deeply ingrained into American culture; therefore, it may be challenging to see racism apart from regular socialization. Members of a majority group may lack understanding of what is at stake simply because they have not suffered disadvantages due to the color of their skin, and they "have never had to think or operate differently in the world to avoid racist encounters."[15(p66)] Patient or family preferences about the staff who provide care may at times be reasonable, but this is not acceptable when the objection is based on race.

"I prefer hot tea to cold" is an example of preference. This choice resides within the individual and does not assign more value to one over the other. Prejudice comes from a conscious or unconscious predetermined idea of something not based on experience or reason. Hot tea moves from preference to prejudice when the choice is made based on a belief or thought, such as chilled tea is not *real* tea, not based on individual taste. Prejudice moves toward racism when this thought or belief contributes to the oppression or unequal distribution of power of one race over another. In the case study, the decision to reassign and continue to prevent Black and brown-skinned clinicians from doing their job is racism.

Autonomy

The charge nurse, Mic, follows a basic premise of patient autonomy. The principle of respect for autonomy allows or enables patients to make their own decisions. Autonomy requires the clinician to provide sufficient information to bridge the gap between the patient and the provider, so that patient decisions and goals are informed. It also implies that these informed decisions are honored by and not coerced by the health professional. Based on the vulnerability of the patient and the assumed authority or power of the clinician, patient autonomy may outweigh other principles. From a deontological perspective, where right and wrong are determined based on the action, not the consequence, honoring patient autonomy is the right action.[16]

Nonmaleficence

Conversely, using a consequentialist view, the harm resulting from an action determines right and wrong, not the action itself.[16] Nonmaleficence involves the duty to avoid harming others, typically regarding treatment procedures and patients' rights; however, it also considers how clinicians are treated. Mistreatment includes psychological damage resulting from discrimination and racism. Because racism harms clinicians emotionally and psychologically, it violates the principles of nonmaleficence.

Justice

The ethical principle of justice concerns the distribution of benefits and burdens. Reassignment of staff affects the entire team in terms of acuity and resources by placing a greater number of patients and expectations within one assignment. Creating an uneven distribution of resources may affect each patient differently. With the limited staff available, time per patient is reduced, and timely response may also be affected. The degree of injustice is situational and time dependent. A strong health care team can provide safe and effective care if arrangements are temporary. If acuity is high, additional resources may be requested. The situation may or may not look any different than if acuity increased unexpectedly during a shift unrelated to staffing or if a clinician became suddenly sick. However, frequent reassignment tests team resilience, and increased work-related stress and burnout may develop.

Duty to Treat

The duty to treat is protective to those vulnerable and in need of care. This duty is held by many clinicians and often requires taking on more risk and burden to treat patients.[17] The absolute self-sacrificing implication of this duty was tested during the COVID-19 pandemic when the personal health risk of clinicians was weighed against their duty to treat. McConnell[17] provided an ethical argument for abstaining from work given the risks posed by COVID-19, especially without proper personal protective equipment. Without proper personal protective equipment, the duty to treat is not absolute after weighing against the health risk involved. Does racist behavior also justify a refusal to treat? Nurses use empathy and compassion to place patients' behaviors in perspective, especially at the end of life, when people are, at times, their worst. When a patient's vulnerability is high, such as at the end of life, permitting racist behavior may be the right action. Selecting this course is situational and requires accountable harm reduction for those involved.

ETHICAL TENSION/DILEMMA

The ethical tension in the case study arises between patient autonomy, the right or need of the patient and family to have care according to their wishes, and the psychological harm that results from reassignment on the individual, team dynamics, and the organization.

Autonomy Over Nonmaleficence

In the case study, the patient's autonomy is honored, and the patient's care (duty to treat) was not compromised. There are levels of harm identified at the individual and team levels. It may be tempting to conclude that harm does not exist because the CHHA, Ax, was able to compartmentalize the event in order to prioritize patient needs. However, the comment made to the clinical manager, "Put your feelings in your pocket," suggests the presence of unresolved harm. Although the clinical manager debriefed Ax regarding the situation, a better recourse would have been for the team to acknowledge the racial discrimination, assess the harm experienced by Ax, offer support, and include Ax in the decision-making process. These actions address the power imbalance created by the event.

There is also evidence of collateral damage when the rest of the care team witnesses the racist event. Racism was not acknowledged and further accommodated by a note restricting people of color from caring for the patient. The anguish of these actions is heard in another nurse's words: "This cuts like a knife."[2] Assuming that Ax, the victim of the event, was able to continue caring for patients does not mean that harm is not valid in others. A note in

the EHR is a discriminatory gesture, a visual statement declaring the value of one race over another. These gestures, assumed to be minor, can activate posttraumatic emotions. The degree of harm is also related to the frequency of similar tolerated behaviors.

Third, the nurse, Mic, nor the clinical manager, Chris, had the skills necessary to deal with the dilemma effectively. It is tempting to forget and move on with a good outcome shown in the daughter's letter of gratitude. However, silence and inaction may be the most harmful consequence because they perpetuate the status quo and raise everyone's tolerance for racism.

Nonmaleficence Over Autonomy

If the nurse held that reassignment would not be made based on skin color, the situation would escalate. One of the greatest fears of clinical staff, especially bedside nurses, who may not necessarily feel empowered or supported to make decisions, is that they will experience disciplinary action if the family complains. This fear may contribute to tolerating inappropriate behavior from patients and families. If her request for reassignment is not allowed, the daughter may take her mother out of hospice care, potentially harming the patient. In an inpatient hospice setting, patients frequently need urgent expert care. They are typically nearing the end of their life with only days to hours left. Not providing timely care may lead to adverse outcomes. If the nurse negotiates a compromise with the daughter, continuing to care for the patient may be harmful to the CHHA, Ax, and other Black and brown-skinned staff, knowing the nature of the request and not having the racial event acknowledged.

In summary, following only the duty of autonomy may benefit the patient but harms clinicians, whereas nonmaleficence harms both the patient and clinicians. Reassignment of staff in this case study was the right action for the patient and family. Reassignment of staff based on racism is the wrong action for the clinician, the organization, and staff. A decision not to reassign staff may also be the wrong action for the clinician. Following the duty of autonomy may seem the *most* right, but it does not provide a strong enough argument. In addition, each clinical case may present differently. The degree of harm and the potential for reducing harm may shift for both patient and clinician. The solution is therefore situational, and not universal.

Potential Solutions

A framework to guide organizations and individuals navigating patient requests for reassigning staff is available.[18] First, develop the ability to recognize explicit racial behavior and more subtle forms of racism such as microaggressions. Second, develop skills for responding to inappropriate behavior, such as knowing what to say to minimize escalation and optimize relationships. Third, develop strategies to support those who experience or witness mistreatment. It is important

TABLE Responding to Microaggression

Training	Description
ACTION model	**Ask** clarifying questions Come from **curiosity**, not judgment **Tell** what you observed in a factual manner **Impact** exploration—discuss what the impact of the statement was **Own** your own thoughts and feelings around the situation **Next** steps
ERASE framework	**Expect** that mistreatment will happen **Recognize** when mistreatment occurs **Address** the situation in real time **Support** the trainee after the event **Establish** a positive culture
Open the Front Door (OTFD tool)	Start the conversation with what is **Observed** How the comments was interpreted (**Think**) How it made the recipient **Feel** What the **Desired** outcome might be
Stop, Talk, and Roll	**Stop** problematic verbal or electronic conversations **Talk** through tough encounters with a supervisor **Roll** on by seeking support through mentorship or employee assistance programs
XYZ	"I feel **X** when you say **Y** because **Z**" Focusing on what s observed (behavior) and the recipient's thoughts and feelings using "I" statement.

Adapted from Wittkower et al.[19(p6)]

to emphasize that inaction "may inadvertently signal to the patient and equally concerning bystanders that the behavior is acceptable."[18(p79)]

There are 27 established training programs for addressing racism, including the ACTION model; the ERASE framework; the OTFD tool; Stop, Talk, and Roll; and XYZ (Table).[19] These tools remind individuals to advocate for themselves by stopping a racial conversation, talking through a tough patient encounter with a peer or supervisor, and, after a shift, "rolling on out" by seeking support through mentorship or an employee assistant program.[20] The tools provide scripts for effective communication, which help to foster awareness and reduce defensiveness. Training frameworks stress the approach to be prepared by practicing each tool individually and in simulation or role-play scenarios.

A decision tree for navigating patient reassignment requests considers 5 ethical and practice factors: medical condition, decision capacity, option for responding to the request, reasons for the request, and considering the effect of the decision on the clinician (Figure).[3] In our case study, key factors include the patients' vulnerable medical condition, the need for the daughter to act as her mother's surrogate decision-maker, consideration for allowing the reassignment or not allowing the reassignment, identification that the request is based on skin color, a real-time assessment of available resources for a reassignment, and a discussion with the CHHA, Ax, and the staff about how the decision will affect them. In all cases, the patient's medical condition drives initial decisions, followed by accurate identification of the reason behind the request.

A request that seems racist may be clinically and/or ethically appropriate. Requests based on bigotry may be attributed to delirium, dementia, or psychosis.[3] In these situations, the patient should not be held ethically responsible. Reassignment may also be appropriate for religious, cultural, or language reasons. Further, a patient may have had a negative personal experience with people of a particular race or ethnic group, such as a veteran with posttraumatic stress disorder who refuses treatment from a clinician of the same ethnic background as former enemy combatants.[3] Patients who are members of racial or ethnic minorities may request racially concordant providers because of a history of discrimination or other negative experiences with the health care system that have resulted in mistrust.[3] These situations are usually straightforward and justifiable. It is therefore reasonable to accommodate when possible. Anticipated harm to staff may be lessened or abated by sharing the reason for the decision and acknowledging that this action does not condone racial behavior.

The following examples of individual and institutional responses empower real-time resolution. An institutional

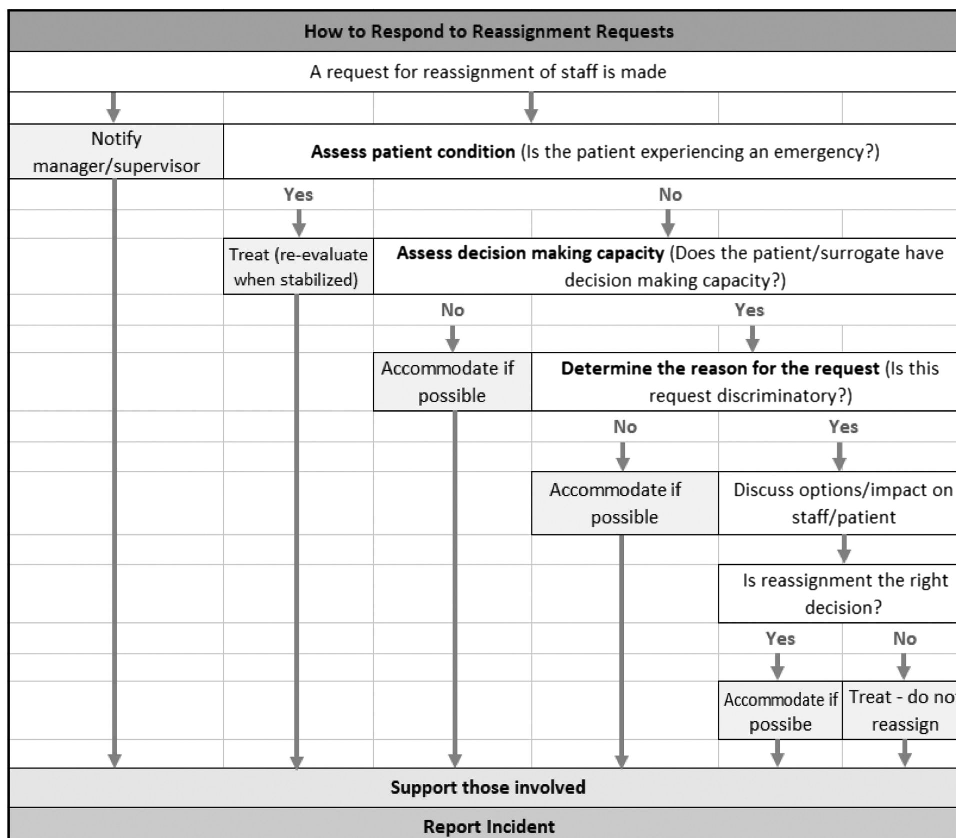

FIGURE. How to respond to reassignment requests adapted from Paul-Emile et al.[3(p70)]

response includes a code-of-conduct display for patients, visitors, and staff that clearly states that discriminatory language and behaviors are not tolerated.[21] The code is displayed in view of patients and visitors to deter racism and used as a visual reminder if necessary. Scripting for addressing interpersonal racism from patients includes "racist language is not acceptable in our center, please be respectful."[21] Staff real-time response to witness racism is a meaningful strategy because it addresses the inappropriate behavior and supports the target. This may include a statement such as "discriminatory remarks are not tolerated here; please remember that as we take great care of you."[21] Supporting a victim of discrimination should happen as soon as possible to create an environment of solidarity, such as "I am sorry that happened. How can I support you?"[21] When deciding to reassign care, involve the clinician targeted to protect him/her from further harm, such as "I am willing to assume care of this patient, how you would like to proceed?"[21]

LESSONS LEARNED

The most significant harm identified in the case study is that of racism. Therefore, the right action involves a resolution of racism to prevent harm. Essential strategies include preparation (plan for what to do before it happens), approaches to discrimination (what to do when it happens), and growth (what to do after it happens). A decision tree to separate a request with nondiscriminatory bigotry-type motivations from racism should be identified and upheld. When the request is racist, staff working at the point of care need clear direction and skill to navigate the right action. Direction begins with an explicit declaration that racism is not tolerated. The reality that racism exists and is experienced is compassionately recognized and not minimized. Staff education and training in effectively navigating racial discrimination, including scripting and simulated role play, are incorporated into onboarding, professional development, and clinical competency. There are clear reporting procedures for racial discrimination and expectations of learning and healing from these events. There is a shared authenticity and care for those who fall victim to these events, with levels of support available in the form of safe space discussion, mentorship, and external support.

Racism may not be blatant, but these situations feel wrong. Information obtained from feelings is as important as what one thinks is right and wrong. Self-awareness and self-development help to refine these feelings into diverse ways of knowing. Early philosophers, notably Aristotle, argue that a virtuous individual who practices courage, compassion, integrity, and justice will be intuitive, knowing what to do in a particular situation or conflict.[22] This argument implies that the right action involves moral thinking and reason, alongside an enlightened individual who acts with compassion and heart. When a situation is not clear, the right character makes the right choice.

CONCLUSION

Resolving racial discrimination in patient care is a moral imperative and a call to action. It requires a courageous moral community that brings racism to light and systems that allow accountability and growth. Talking about racism is difficult, but nurses need to have these conversations. Together, we gain insight and humility to call out personal racism and then step up for those affected.

References

1. Reddy S. How doctors deal with racists patients. *Wall Street Journal*. https://www.wsj.com/articles/how-doctors-deal-with-racist-patients-1516633710. January 22, 2018. Accessed May 18, 2022.
2. Truitt AR, Snyder CR. Racialized experiences of Black nursing professionals and certified nursing assistants in long-term care settings. *J Transcult Nurs*. 2020;31(3):312-318. doi:10.1177/1043659619863100.
3. Paul-Emile K, Smith AK, Lo B, Fernández A. Dealing with racist patients. *N Engl J Med*. 2016;374(8):708-711. doi:10.1056/NEJMp1514939.
4. Alexander GR. Defining racism. National Commission to Address Racism in Nursing. https://www.nursingworld.org/~49f737/globalassets/practiceandpolicy/workforce/commission-to-address-racism/final-defining-racism-june-2021.pdf. June 2021. Accessed May 18, 2022.
5. Thomas-Hawkins C, Zha P, Flynn L, Ando S. Effects of race, workplace racism, and COVID worry on the emotional well-being of hospital-based nurses: a dual pandemic. *Behav Med*. 2022;48(2):95-108. doi:10.1080/08964289.2021.1977605.
6. Popper-Giveon A, Keshet Y. The secret drama at the patient's bedside-refusal of treatment because of the practitioner's ethnic identity: the medical staff 's point of view. *Qual Health Res*. 2018;28(5):711-720. doi:10.1177/1049732318755676.
7. American Nurses Association. Commission survey finds racist acts prevalent in nursing, addressing racism in nursing, ANA on the frontline. *Am Nurse J*. 2022;17(2):32.
8. Chandrashekar P, Jain SH. Addressing patient bias and discrimination against clinicians of diverse backgrounds. *Acad Med*. 2020;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S33-S43. doi:10.1097/ACM.0000000000003682.
9. Hart A. The discriminatory gesture: a psychoanalytic consideration of posttraumatic reactions to incidents of racial discrimination. *Psychoanal Soc Work*. 2019;26(1):5-24. doi:10.1080/15228878.2019.1604241.
10. Doede M. Race as a predictor of job satisfaction and turnover in US nurses. *J Nurs Manag*. 2017;25(3):207-214. doi:10.1111/jonm.12460.
11. Ragins BR, Ehrhardt K, Lyness KS, Murphy DD, Capman JF. Anchoring relationships at work: high quality mentors and other supportive work relationships as buffers to ambient racial discrimination. *Pers Psychol*. 2017;70(1):211-256. doi:10.1111/peps.12144.
12. Kubsch S, Tyczkowski B, Passel C. Altruism and the difficult patient: quantitative research. *J Holist Nurs*. 2021;39(1):56-57. doi:10.1177/0898010121999511.
13. Agar J. Black nurse sues after White patient asks for no Black caregivers. Grand Rapids. Advance Local Media LLC. October 2017. https://www.mlive.com/news/grand-rapids/2017/10/black_nurse_sues_after_white_p.html. Accessed May 18, 2022.
14. Biswas J. Nurse sues hospital, saying it obeyed patient who didn't want a Black caregiver. *ABC News Network*. August 2018. https://

abcnews.go.com/US/nurse-sues-hospital-obeyed-patient-black-carer/story?id=57216585. Accessed May 18, 2022.
15. Thom KD. Building blocks to being anti-racist. *Experience Life Magazine*. 2022;64-69. https://www.expereincelife.com.
16. Tanner C, Medin DL, Iliev R. Influence of deontological versus consequentialist orientations on act choices and framing effects: when principles are more important than consequences. *Eur J Soc Psychol*. 2008;38(5):757-769. https://doi.org/10.1002/ejsp.493.
17. McConnell D. Balancing the duty to treat with the duty to family in the context of the COVID-19 pandemic. *J Med Ethics*. 2020; 46(6):360-363. doi:10.1136/medethics-2020-106250.
18. Wilkins KM, Goldenberg MN, Cyrus KD, Hyacinth M, Conroy ML. Addressing mistreatment by patients in geriatric subspecialties: a new framework. *Am J Geriatr Psychiatry*. 2022;30(1):78-86. doi:10.1016/j.jagp.2021.04.011.
19. Wittkower LD, Bryan JL, Asghar-Ali AA. A scoping review of recommendations and training to respond to patient microaggressions [published online October 6, 2021]. *Acad Psychiatry*. 2021. doi:10.1007/s40596-021-01533-9.
20. Sandoval RS, Afolabi T, Said J, Dunleavy S, Chatterjee A, Ölveczky D. Building a tool kit for medical and dental students: addressing microaggressions and discrimination on the Wards. *MedEdPORTAL*. 2020;16:10893. doi:10.15766/mep_2374-8265.10893.
21. Chary AN, Fofana MO, Kohli HS. Racial discrimination from patients: institutional strategies to establish respectful emergency department environments. *West J Emerg Med*. 2021;22(4):898-902. doi:10.5811/westjem.2021.3.51582.
22. Swan E. What are White people to do? Listening, challenging ignorance, generous encounters and the 'not yet' as diversity research praxis. *Gend Work Organ*. 2017;24(5):547-563.

For more than xx additional continuing education articles related to depression, go to NursingCenter.com.

Lippincott® NursingCenter®

NCPD Nursing Continuing Professional Development

INSTRUCTIONS

Racial Discrimination in Patient Care – Preserving Relationships with Integrity

TEST INSTRUCTIONS

- Read the article. The test for this nursing continuing professional development (NCPD) activity is to be taken online at **www.nursingcenter.com/CE/JHPN.** Tests can no longer be mailed or faxed.
- You'll need to create an account (it's free!) and log in to access My Planner before taking online tests. Your planner will keep track of all your Lippincott Professional Development online NCPD activities for you.
- There's only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.
- Registration deadline is September 5, 2025.

PROVIDER ACCREDITATION

Lippincott Professional Development will award 2.0 contact hours for this nursing continuing professional development activity.

Lippincott Professional Development is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.0 contact hours. Lippincott Professional Development is also an approved provider of continuing nursing education by the District of Columbia, Georgia, West Virginia, New Mexico, South Carolina and Florida, CE Broker #50-1223. Your certificate is valid in all states.

Pament: The registration fee for this test is $21.95.

DISCLOSURE STATEMENT

The authors and planners have disclosed that they have no financial relationships related to this article.