

Healthcare Justice, Medicare, and the Racial Desegregation of Hospitals in the South

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September 27, 2023

DOI: 10.3912/OJIN.Vol28No03PPT77b

Article

Abstract

This article explores the advent of Medicare, the process of desegregation of hospitals in the South, and the resistance to this governmental oversight. Events at the Medical College Hospital of South Carolina are described as an exemplar to illustrate the struggle for healthcare justice for Black Americans where the struggle for racially integrated healthcare ended in a hospital workers strike. Four hundred Black women walked off their jobs and marched in picket lines for 113 days without pay before the economic and human rights issues were resolved. As the cause for racial justice continues in America, an understanding of this story which represents the beginning of the long struggle for health equity which impacts our profession, and our patients, can benefit all nurses. This article reviews this important exemplar in its time period and offers a description of current efforts and implications for the profession of nursing.

Key Words: race, racism, Black healthcare, nursing, labor history, picketing, unions, nursing education, southern politics, national politics, healthcare, desegregation, strikes, Southern Christian Leadership Conference, Medicare

In the 50 years since the passage of the Civil Rights Act (1964), the need for public protest to stand for racial justice in healthcare continues in America. In 2020 in Boston, the faculty, staff, and residents at Brigham and Women's Hospital at Harvard University stood shoulder-to-shoulder as an anti-racist protest following the killings of Black Americans in their community (Okaka, et.al., 2020). Despite the abundance of healthcare services in Boston, they had discovered a 25-year difference in life expectancy between White and Black citizens in surrounding communities. A similar discrepancy, although not as severe, has been found in Charleston, South Carolina (SC). In 2022, Suddeth reported a difference in life expectancy in people separated by a small river in Charleston. In a white suburb of Charleston, with an average income of \$98,000, the life expectancy is 81.1 years; however, people living just across the river in a predominantly black neighborhood, with an average income of \$28,000, have a life expectancy of 66.6 years. These are just two of many examples of racial health inequities that exist in communities across our country. In the scenario above at Boston Women's and Children's, residents began to reimagine the hospital as a pivotal convening place in the fight for racial justice.

This article describes the history of that fight for equal racial access to healthcare in this country and particularly in Charleston, SC. As we continue to seek racial justice in America, exploring the history of the struggle and its implications is beneficial for all nurses. Understanding our past while searching for solutions to this continuing issue of healthcare access inequality, can better inform efforts to mitigate the issue of racism in healthcare for the future. As a profession, nurses must come to terms with the impact racism has had on Black and Brown nurses and develop strategies to move forward together as an antiracist profession.

Racism has been declared a public health crisis (CDC, 2021; The Whitehouse, 2021). In an integrative review of the nursing literature on race and racism (Ihedura-Anderson & Shingles, 2021, *Public Health Nursing*, 2021, 38: 115-130) the first theme that emerged was the need to break the culture of silence. Racial discussions in nursing are often one sided, with nurses of color generally being vocal about their experiences while white nurses remain largely silent (DiAngelo, 2018). All nurses must be educated and understand the truth of our history as a common ground from which to begin joint discussions about race and the history of healthcare to find solutions to implement together.

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The first theme that emerged was the need to break the culture of silence.

This article also explores the advent of Medicare in the United States (US), the process of desegregation of hospitals in the South, and the resistance to this governmental oversight. The Medical College Hospital (MCH) of SC will be used as an exemplar to illustrate the struggle for healthcare access for Black Americans and the fight for equal pay for Black healthcare workers, largely Black women nursing assistants. In the 1960s, the federal government worked closely with civil rights activists in SC and particularly Charleston, to accomplish the goal of providing equal healthcare to African Americans as well as social justice for the Black hospital workers who were discriminated against with poor working conditions and pay. This history is just beginning to be told as part of our professional legacy. The article will connect the national political, social, and racial climate to one hospital in the South and explain the national human drama at a local level and reflect it back to the national government's attempt to grapple with the racial struggle for healthcare access, human dignity, and equal justice.

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1946: The Hill Burton Act

In 1946, Post-World War II, The Hill Burton Act ([1946](#)) was passed by Congress and expanded Healthcare Services nationally by providing money for hospital construction across the US. Initially, allocation of funds required assurances that newly constructed facilities would be available to all people of the community, regardless of race ([Beardsley, 1987b](#)). The federal government matched local and state funds on large scale healthcare construction projects to achieve the goal of healthcare expansion for both races. After numerous delays, MCH of SC President Dr. Kenneth Lynch announced that the hospital would receive nine million dollars for the new medical center hospital as well as, a tuberculosis hospital, and a hospital for Negroes ([Cauthen, 1950](#)). The MCH of SC leaders utilized the Hill Burton funds to construct their own hospital, separating from Roper Hospital, an all-white hospital where medical students were trained.

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The Hill Burton Act ([1946](#)) included a last-minute exception before it passed, stating, in localities where "separate facilities were planned for a separate population," Hill Burton money could still be used to construct healthcare facilities, although not fully racially integrated. South Carolina had taken advantage of the loophole by building a small one-story hospital for Negro physicians to admit patients and a 10-story large medical center which would have segregated facilities with Whites being admitted to one wing of the hospital while Black patients would be admitted to the opposite wing of the hospital. However, according to the federal guidelines, racially segregated services were required to be of 'like quality' extending the 'separate but equal doctrine' of the Plessy VS Ferguson ([1896](#)). Hill-Burton expanded hospital access to Black patients with the number of hospital beds available increased by 60% nationwide. Access also increased for Whites by 72%; however, 86 hospitals with 4951 beds were added to counties with high black populations and 107 hospitals were built in counties with low black population concentrations ([Reynolds, 1997](#)).

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The effect of the separate but equal clause created the H-shaped architecture of Hill Burton hospitals, including the MCH of SC, where on each floor, one wing of the H shape was for Whites and the other wing of the H shape was for Blacks. The connecting hallway was used for physician offices and laboratories utilized by both groups. In spite of the lack of integration, the Hill Burton Act ([1946](#)) dramatically expanded healthcare services available to Black Americans.

In 1962 a major court case in North Carolina began the legal foundation to revoke the separate but equal clause when the Black dentist George Simkins sued Moses Cone Hospital because they refused to admit his Black patient, who had high fever and sepsis ([Burrows & Burney, 2019](#); [Smith, 1999](#)). His patient was extremely ill but was denied admission because of his race. Though initially lost the case was won on appeal, beginning the erosion of the 'separate but equal' clause of the Hill Burton Act ([1946](#)) ([Burrows & Burney, 2019](#)). In an opening telegram to the NAACP conference on hospital integration, in May 1962, President Kennedy told the assembled members that the attorney general would argue against the clause of the Hill Burton Act that sanctions segregation. In South Carolina the National Association for the Advancement of Colored People (NAACP) was also working to end discrimination in hospital care. NAACP lawyers filed a lawsuit against the Orangeburg Regional Hospital on behalf of a Negro mother and young daughter who refused to leave the waiting room while seeking urgent medical care in 1963 and were charged with trespassing ([NAACP files suit, 1964](#)). This hospital was merely fifty miles from Charleston and the action of the NAACP in Orangeburg was carefully noted.

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1963: John Kennedy Takes Racial/Moral High Ground

In a televised message to the people of the United States, President John Kennedy pointed out that "simple justice requires that public funds to which all taxpayers contribute regardless of race, cannot be spent to subsidize or encourage racial discrimination, neither directly by overt discrimination in any form

from the government nor indirectly allowing federal funds to be used in a discriminatory or racially unfair way” (Smith, 1999, p 96). Kennedy had won the presidency by a very narrow margin against Richard Nixon. Black voters had supported John Kennedy by 78%, and he knew, with the next election rapidly approaching, if he did not carry the black vote, he would lose to Nixon this time (Smith, 1999). He needed to reassure Black Americans that he understood their plight and would deliver for their welfare.

Only a few months later, before the election, President Kennedy was assassinated. The country mourned, reeling in shock that he was gone. Just days following Kennedy’s assassination, the newly sworn in President Lyndon Johnson took up the civil rights cause, invoking the deceased Kennedy by saying “there would be no more fitting memorial to his legacy than the passage of the Civil Rights Act” (Smith, 1999, p 100). The President met right away with civil rights activist Dr. Martin Luther King, marking the beginning of a partnership between Johnson, the federal government, and King, to bring racial equality to America and particularly to healthcare. It was this collaboration between civil rights activists, legal and healthcare professionals, and branches of the federal government that ultimately achieved hospital desegregation (Burrows & Burney, 2011).

A racially divided healthcare system had evolved, particularly in the South where Blacks were either excluded altogether from healthcare, relegated collectively to a “colored” ward which might be located in the basement or an unrenovated older hospital wing, or sent to a poorly funded Black private hospital, many of which had closed their doors before 1963 because of lack of funds (Beardsley, 1987a). In 1959, in the North, 83% of general hospitals offered patient care on an integrated basis; however, in the South only 6% of hospitals offered care without racial restrictions (Reynolds, 1997).

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Medical education for Blacks was extremely limited in that all but two black medical schools had closed following the Flexner report (<https://archive.org/details/carnegieflexnerreport>) and few hospitals offered internships and residencies to Black physicians (Burrows & Burney, 2019; Reynolds, 1997). There were simply few well trained Black physicians to meet the demands of the growing black population in a segregated healthcare system in the South. Because of the racial exclusion of Black physician in specialty residency programs, there were almost no Black physician specialists. Black medical school graduates could not easily get residencies; many were forced to practice “general medicine,” making it difficult to get admitting privileges to specialty hospitals and certainly no faculty positions in medical schools (Thomas, 2011). Black physicians had to form their own medical organization as they were barred from the American Medical Association (<https://perspectivesofchange.hms.harvard.edu/node/97>).

The Politics of Desegregation of Healthcare and Civil Rights

The passing of the Civil Rights Act (1964) made it illegal for hospitals to discriminate by race in patient admissions or healthcare worker employment; however, the government had no leverage to compel hospitals into compliance. Passage of Title VI legislation (1964) providing Medicare funding for older American’s healthcare finally provided that leverage as the government could withhold all funds from the hospital until civil rights compliance was achieved (Reynolds, 1997).

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Thus, when Congress passed the Title VI Bill (1964) providing Medicare funding for everyone over 65 years of age, the government’s efforts to address these racial inequalities began. Going forward, hospitals had to be ‘certified’ as racially nondiscriminatory, or Civil Rights compliant, to receive Medicare funds. Medicare promised to provide about one third of all hospital revenue when paying for the elderly who had, for the most part, been previously uninsured (Burrows & Burney, 2019). Most hospitals needed money, and perhaps reluctantly, they cooperated. But not

all hospitals did cooperate, especially in the South.

1964: The MCH President Takes the Reins

At the same time that the Title VI (1964) legislation was being enacted, at the MCH of SC (built with Hill Burton funds), Dr. William McCord, MD, PhD, took over as interim president. He was born in Durban, South Africa, to American missionary, physician parents who provided healthcare to the Zulu tribe (Noble & Parle, 2014). His early life in South Africa occurred during the period of strict apartheid where race and gender stratifications were hierarchical and absolute. After attending medical school in Louisiana, and earning a PhD in chemistry, Dr. McCord came to MCH of SC to teach. As interim president, when the Department of Health, Education and Welfare (DHEW) required his signature assuring that the hospital was in compliance with Title VI and the Civil Rights Act, and therefore qualified to receive not only Medicare but any and all federal

funds, he stated that the MCH did not discriminate on the basis of race or color. As such, it qualified for full funding by the federal government, which at the time amounted to \$28,000 yearly of funds for medical research ([William McCord Presidential Papers, ARC 104](#)).

Following passage of the Title VI (1964) legislation, the DHEW was tapped as the division of the government that provided compliance oversight to hospitals, ensuring they did not have racist practices and were Civil Rights Act compliant. Medicare was scheduled to go into effect July 1, 1966. In preparation, 19 million elderly Americans needed to be enrolled, fee schedules had to be set, and nearly 7,500 hospitals needed to be certified in compliance with health and safety standards as well as Title VI ([Burrows & Berney, 2019](#)). The biggest fear was that government compliance would not be verified in time because of a lack of trained compliance officers and that older Americans, Medicare recipients, might be denied care by hospitals whose compliance had not been verified and were therefore not eligible to receive Medicare funds. Because of the necessity of visiting the sheer volume of hospitals, civil rights activists across the country were encouraged to file complaints if violations of the Civil Rights or the Title VI Acts were known to exist in hospitals in their communities.

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In February of 1965, Dr. McCord sent a memorandum to all deans and administrators noting that there must be no racial discrimination practiced within the institution ([William McCord Presidential Papers, ARC 104](#)). In March 1965, he informed the college board of trustees that all signs referencing “White” or “Colored” had been removed from waiting rooms, bathrooms, entrances, and clinical services throughout the institution ([MUSC Board of Trustees Minutes, ARC 800](#)). However, on May 10, 1965, he was notified that a complaint had been filed against the MCH stating that Negroes were consistently assigned to beds on the East wing where visiting hours were restricted to one hour a day, while Whites were assigned to beds on the West wing where visiting hours occurred for three hours per day. Federal grant funds were immediately cut off to the MCH (correspondence to Ben DeBerry, Assistant Attorney General, June 18, 1969, page 3, [William McCord Presidential Papers, ARC 104, 1969 series 1](#))

An investigative team was sent to the hospital on May 26 and found the MCH to be in non-compliance with title VI as follows:

1. No Negroes were admitted to the psychiatric services
2. Cafeteria use appeared to be segregated
3. The continued use of Roper Hospital, a white only hospital with discriminatory practices in employment and admissions for training purposes, violated the spirit of Title VI

a local committee of Black leaders was formed and met regularly with the hospital administration to correct the non-compliance.

At the direction of the DHEW a local committee of Black leaders was formed and met regularly with the hospital administration to correct the non-compliance. Following actions that produced compliance, research funds were released to the hospital. By July 1966 civil rights compliance was achieved mostly voluntarily in over 92% of the nation’s hospitals ([Burrows & Burney, 2019](#)). A letter in March 1966 from the DHEW to SC Governor Robert McNair revealed the concern that many SC hospitals remained out of compliance with the Civil Rights and title VI (1964) legislation, and therefore were Medicare ineligible. The DHEW letter suggested that they convene a broad-based meeting of the state hospital association leadership and DHEW representatives to discuss strategies to remedy this situation statewide ([Political Collection, Robert McNair](#)). However, it is doubtful that this meeting ever occurred as there is no evidence of further correspondence.

In July 1968, MCH of SC received another complaint. During this visit from the DHEW, inspectors focused on the lack of an affirmative action plan and failure to provide a comprehensive recruitment program for minority students. They also pointed out that the faculty physicians were all white. During the visit, members of the community informed the visiting committee that patients had been changed to different rooms to give the appearance of mixing races before the DHEW visit ([William McCord Presidential Papers, ARC 104](#)). Informal meetings were held between the black community committee and a local group of Hospital Workers Union 1199 to discuss these racial issues ([Hopkins, 2016](#)). It was reported that the hospital administration had refused to meet with the employees when they requested a meeting to discuss these concerns. ([Fink, 1983, p.12](#))

1968: Local Union 1199 Formed and Tension Builds

Mary Moultrie, a nurse’s aide who had worked previously in a unionized hospital in New York, led meetings of hospital employees who were complaining of poor pay and poor treatment, which they felt was racially motivated. Rosetta Simmons led hospital workers from the adjacent County Hospital to join with MCH workers for the same concerns ([Hopkins, 2016](#)).

They knew they needed wider visibility to succeed in making changes regarding racial discrimination in the hospital ([Fink, 1983](#)). They contacted Hospital Workers Union 1199 for organizing logistics and leadership and invited the Southern Christian Leadership Conference (SCLC) to join them to obtain national press coverage and recognition.

The hospital workers reported that nurses' aides who were Black were making \$1.30 per hour and that White aides were making \$1.60 per hour ([William McCord, ARC 104, 1969](#) series 1, box 1, Folder 4); the DHEW was threatening to withhold research dollars if these violations were not remedied. In 1965, the amount to be withheld for racial noncompliance was \$28,000; by 1969 the amount of research dollars threatened by noncompliance had grown to \$12 million dollars ([William McCord Presidential Papers, ARC 104](#)).

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After an aborted meeting between the college president and the disgruntled workers, the police were called. When the police arrived, a crowd of hospital workers had assembled and were singing protest songs. They were told to disperse or be arrested; the crowd dispersed, and the 12 original worker leaders who had spearheaded the meeting were fired for dereliction of duty. The nursing director and her supervisors sided with the administration, delivering termination letters to the employees. When the MCH administration refused to rehire the 12 hospital workers, on March 20, 1969, four hundred workers walked out of two hospitals and the strike began ([Hopkins, 2016](#)).

1969: Southern Christian Leadership Conference Joins with Union 1199

Andrew Young, a leader of the SCLC, arrived in Charleston to galvanize black community support by organizing black churches and congregations to provide meeting places and marchers. Meetings took place nightly with Ralph Abernathy and Coretta Scott King rallying the strikers. The National Hospital Workers Union 1199 organized food and logistics. The Auto Workers Union (UAW) and the Longshoremen Union provided solidarity and financial support ([Fink, 1983](#)).

Andrew Young garnered national attention and organized a boycott of local businesses by the black community. The strike was moved to the downtown business district and into the historic district. This was the height of tourist season. Young said, "It is only when you create the same kind of crisis in the life of the community, as you have in the lives of the workers, that the community will give in" ([Fink, 1983](#), p.15).

Charleston businesses started to apply pressure for a resolution.

The governor called out the national guard and the city was placed under curfew ([Hopkins, 2016](#)). Charleston businesses started to apply pressure for a resolution. The strikers posed 'shop ins' where strikers crowded aisles and checkout lines. The Mother's Day March brought Coretta Scott King and over 12,000 marchers. Coretta Scott King said, "Hospital workers have been working full time jobs at part-time pay...After all \$1.30 is not a wage. It is an insult" ([The Charleston Hospital Workers Movement, 2013](#), para. 3). King went on to say that black women are the most discriminated against of all women.

June 1969: The DHEW Applies Pressure

On June 4, 1969, the DHEW cited MCH with 37 civil rights violations and stated the hospital must rehire all dismissed workers to come into compliance ([Fink, 1983](#)). On June 9th the SC governor accepted responsibility for the state to comply with the DHEW orders. He said that the state would raise the minimum wage to the federal level of \$1.60 an hour, and rehire the 12 dismissed workers, without any official recognition of the union. The state agreed to a grievance procedure. The signing date of June 12, 1969 was set ([Fink, 1983](#)).

However, just hours before the assigned meeting, SC Senator Strom Thurmond, a staunch segregationist, handed political blackmail to the President. Nixon had won the presidency by a narrow victory. Thurmond told Nixon, "If the state's political strong men were complaining, it would be politically unwise to challenge the (racial) status quo." ([Bowles, News and Courier, June 19, 1969](#), p 22) President Nixon met with reporters, saying that federal funds would be restored regardless of outcome ([News & Courier, June 12, 1969](#)), and MCH President McCord immediately rescinded his pledge to rehire the 12 workers ([Fink, 1983](#)). This maneuver resulted in two more weeks of rising tension, night marches, mass arrests, fire-bombs, and threats by the Longshoremen's union to have a work slowdown and tie up Charleston harbor.

Resolution Reached and Workers Rehired

The ultimate success that led to a resolution is attributed to Daniel Patrick Moynihan, Secretary of Urban Affairs, who intervened in the White House ([Fink, 1983](#)). At his suggestion Nixon sent mediators quickly to Charleston and a settlement was reached. McCord released a terse official

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statement “We have settled.” (Fink, 1983, p.19). With the settlement, all workers were rehired with back pay and pay was raised to federal level with no racially discriminatory practices. A six-step grievance procedure was put in place, and a promise was made to establish a credit union where employees could borrow money.

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Mary Moultrie said in an interview years later, “It was an awakening, a victory for us, a moral victory.” Rosetta Simmons said, “We knew we had to be there for our dignity and respect. We got respect after that; we were treated like human beings” (Walsh, 2009; <https://citadeldigitalarchives.omeka.net/items/show/192>, p31). In July 1969, after 113 days, all workers were rehired, they received back pay, a raise was granted to all state hospital workers to \$1.60 an hour, and the grievance procedure guaranteed that no worker could be fired without the opportunity to have a review of their work record and the firing overturned by a grievance committee of hospital workers of their peers, if they requested ([William McCord Presidential Papers, ARC 104](#)).

Visits to almost 3000 hospitals found that 2000 had changed their discriminatory practices before the team arrived.

From 1966 until 1969 as a result of passage of title VI (1964), more than 7160 hospitals were certified to participate in Medicare; 35 had not been certified but received an opportunity for a hearing. The office of Equal Health Opportunity was still working with 100 hospitals to bring them into compliance and 215 hospitals had decided not to accept federal funds. Visits to almost

3000 hospitals found that 2000 had changed their discriminatory practices before the team arrived ([Reynolds, 1997](#)).

However, workers at MCH had to risk their jobs and pay to bring attention to a nation of the egregious racist practices, brought to light at this prestigious hospital in Charleston, SC ([Hopkins, 2016](#)).

Current Efforts in Nursing Toward Health and Professional Equity

On June 17, 2015 a mass shooting occurred in Charleston, SC, in which nine African Americans were killed during a Bible study at the Emanuel African Methodist Episcopal Church by a white supremacist. Following this tragedy, in a beginning attempt at racial reconciliation, The Board of Trustees of the Medical University of South Carolina ([MUSC], previously the Medical College Hospital) officially acknowledged “grave mistakes of the past.” ([MUSC Sorry, 2015](#) p.1). Publicly expressing regret for racial discrimination that led to the 1969 Hospital Workers Strike described above, they paid further tribute to the strikers and other change agents, acknowledging its unfair treatment of Black employees before and during the Hospital Workers Strike ([MUSC Sorry, 2015](#)). This acknowledgement, almost 50 years after the event, further reported that the MUSC institution is currently focused on greater diversity and inclusion moving toward accountability and transparency to achieve racial equality.

In 2020, when the medical and nursing staffs at Brigham and Women’s Hospital at Harvard University stood shoulder to shoulder in their anti-racist protest, they began an attempt at recognition and reconciliation toward racial health equity in America ([Okaka et.al., 2020](#)). They found that research conducted at their medical center has revealed that Black patients presenting with heart failure were less likely to be admitted to specialized cardiology services compared with their white counterparts, which may in part explain racial inequities in outcomes ([Eberly, 2019](#)). This study revealed not only institutional racial discriminatory practices, but an inherent structural racism included in research protocols, insurance reimbursement, and clinical decision making which converge to disproportionately disadvantage Black patients and create barriers to equal care.

On June 11, 2022, the American Nurses Association (ANA) Membership Assembly took historic action to begin a healing journey by adopting the ANA Racial Reckoning Statement ([ANA, 2022](#)) which began with a definition from the National Commission to Address Racism in Nursing, 2021, as follows:

Racism: assaults on the human spirit in the form of actions, biases, prejudices, and ideology of superiority based on race that persistently cause moral suffering and physical harm of individuals and perpetuate systemic injustices and inequities ([National Commission, 2021](#), para 3).

The ANA has historically led the profession of nursing; however, with this process of reconciliation, nurse leaders have acknowledged that, as an organization it has through omission and commission, caused harm to Black and Brown nurses throughout the history of the organization. For several decades, minority nurses have expressed concern regarding the lack of Black and Brown leaders in the profession of nursing and specifically the ANA, ultimately forming their own organizations. This fragmentation by minority and ethnic nursing groups caused by unequal representation within the ANA, did not provide a forum for mutual understanding and reconciliation.

In 2021 the commission surveyed nurses, finding that minority nurses reported acts of racism were perpetuated by colleagues and people in power ([National Commission, 2022](#)). Fifty-six percent of respondents reported having had an act of racism against them which impacted

For several decades, minority nurses have expressed concern regarding the lack of Black and

them negatively professionally. These included stereotyping, prejudice, discrimination, exclusion, oppression, inequality, and insistence on conformity and assimilation, (ANA, 2022). The ANA Reconciliation proposal states that moving forward, ANA will strive to create antiracist practices and environments; advocate for and provide guidance to report on race and ethnicity in academic and nursing journals; and advocate for appropriate representation of Black and Brown patients in textbooks and educational materials.

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Conclusion: Implications for Nursing Practice

Nursing as a profession and as an academy is beginning to recognize that the practice of teaching cultural competence and social determinants of care has not resulted in the realization of health equity or adequately promoted racial justice for patients. Nor has it historically given minority nurses a professional platform where they can be assured of being treated equally and fairly. (<https://www.nursingworld.org/practice-policy/workforce/racism-in-nursing/RacialReckoningStatement/>).

Current recommendations (Nardi et.al., 2020) to achieve honest forward movement include:

1. Developing processes for critical self-reflection to understand not only structural and institutional racism but also the impact of marginalization and even minor oppression on individuals, nurses and patients;
2. Providing opportunities for racial conversations within the structure of the profession with senior, qualified guides committed to providing support during the interactions;
3. Significantly increasing diversity of nurses in areas of academia, clinical care, and nursing businesses;
4. Providing an honest evaluation of the effectiveness of strategies of outreach to minority nurses; and
5. Enabling pedagogical practices that specifically reduce racism, and other forms of systematic discrimination

Ultimately, facing the truth of our past and engaging with this commitment to reconciliation could move the professional of nursing beyond a cultural focus to an antiracist pedagogy, antiracist professional platform, and an antiracist healing workplace for all nurses and patients in the future.

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Citation: Bennett, C., (September 27, 2022) "Healthcare Justice, Medicare, and the Racial Desegregation of Hospitals in the South" *OJIN: The Online Journal of Issues in Nursing* Vol. 28, No. 3.

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