

You've Got to be Two, Three Times Better Than Anybody Else: Experiences of Black Nurse
Anesthetists in Nurse Anesthesia Education

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DEDICATION

This dissertation is dedicated to Dr. Lena Gould, whose tireless work and steadfast insistence on social justice in nurse anesthesia remains a constant source of inspiration to me, and to Ms. Goldie Brangman, founder and former director of New York City's Harlem Hospital Center School of Anesthesia for Nurses. Ms. Brangman was the first and, to date, only Black president of the American Association of Nurse Anesthetists.

“Our social world, with its rules, practices, and assignments of prestige and power, is not fixed; rather, we construct it with words, stories and silence.”

Richard Delgado and Jean Stefancic

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ABSTRACT

In a recent survey of nurse anesthetists in the United States, ninety percent identified themselves as white/Caucasian, and less than three percent identified themselves as Black. This qualitative study was designed to examine barriers and assistors to Black nurse anesthetists when applying to and during a nurse anesthesia educational program. Interviews were conducted with twelve practicing Black nurse anesthetists, and the resulting data was coded into various themes. The codes identified were grouped into broad categories: Resources, Exclusion, Hazing, Inclusion, and Significance. In the Resources category, the themes identified were: awareness, navigating the system, and funding. In the Exclusion category, the following themes were identified: segregation, I don't belong, proving. In the Hazing category, identified themes were: misidentification, mistreatment, coping strategies. In the Inclusion category, the themes included: representation, mentorship, outreach. In the Significance category, the key themes were: recognition and purpose. The themes were then used to make recommendations for increasing professional diversity, such as the development of formal mentorship programs, increasing representation of people of color in advertising, and the development of training modules dealing with bias and diversity.

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LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nursing
AANA	American Association of Nurse Anesthetists
APRN	Advanced Practice Registered Nurse
CINHAL	Cumulative Index to Nursing & Allied Health Literature
CLS	Critical Legal Studies
COA	Council on Accreditation of Nurse Anesthesia Educational Programs
CON	College of Nursing
CRT	Critical Race Theory
CRNA	Certified Registered Nurse Anesthetist
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
RN	Registered Nurse

Chapter One

Introduction and Background Information

Every year the American Association of Nurse Anesthetists (AANA) conducts a survey asking for demographic information about members. The AANA is a group of nurse anesthetists and student nurse anesthetists, and a person must be currently enrolled in an anesthesia program or have completed one in order to be a member of the organization. In 2017, Rivera reported that the survey was administered to 30, 974 practicing nurse anesthetists. In order to be a practicing nurse anesthesia clinician, one must complete a nurse anesthesia educational program and must pass the nurse anesthesia national certification examination.

The survey was completed and returned by 4851 nurse anesthetists. Ninety percent identified themselves as white/Caucasian, and less than three percent identified themselves as either Black, Hispanic, Asian or American Indian/Alaskan Native (Rivera, 2017). According to the Pew Research Center (2016), in 2016 the adult population of the United States will be less than seventy percent white/Caucasian, with twelve percent being Hispanic, twelve percent Black and four percent Asian. The racial and ethnic make-up of the nurse anesthesia profession does not match the racial and ethnic makeup of American society.

Nurse anesthetists are drawn from the population of registered nurses in the country, because in order to become a nurse anesthetist one needs a Bachelor of Science in Nursing and a minimum of one year of critical care experience (AANA, 2016). According to the Health Resources and Services Administration, in 2015, 90.8% of registered nurses self-identified as female, and 78.6% self-identified as Caucasian. Only 10.8% self-identified as African-American and 8.8% self-identified as Asian.

Because nursing faculty are drawn from the population of registered professional nurses in the United States, it is not surprising that minoritized populations are underrepresented in faculty ranks, as well. Phillips and Malone (2014) state that 12.6% of full-time nursing faculty self-identify as coming from a non-white background, while 6.2% identify as male. Data is not available on the number of nurse anesthesia faculty of color in the country, but clearly the “pipeline” for nurse anesthetists lacks diversity, so is it any wonder that nurse anesthesia lacks diversity, as well?

One might make the argument that nursing is a hegemonic setting. A culturally hegemonic setting provides benefits for one social group at the expense of another (Kneipp, Rowsey, Giscombe, Hodges, Fowler, & Alexander, 2014). The benefits of being the dominant group in any profession include the ability to heavily influence the culture of that profession, to effectively silence dissenting views, and to limit the benefits of the profession to a small group of people. According to Kneipp, et. al., (2014), the “symbolic cues” encountered by persons within that hegemonic environment are influential in terms of educational choices and career path decisions. What symbolic cues are encountered by prospective nurse anesthetists from various racial/ethnic backgrounds? Specifically, what symbolic cues are encountered by Black nurse anesthesia program applicants and students?

The benefits of becoming a nurse anesthetist include enhanced professional autonomy, (because nurse anesthetists independently select and administer anesthetic medications and anesthetic techniques), enhanced professional respect, and a considerably higher level of compensation than that enjoyed by a registered nurse. The highest level of reported compensation for a nurse anesthetist in the United States in 2017 was \$243,550, with the average being \$160,250, as compared to the average salary of a registered nurse at \$68,450 (AANA,

2017). Such a salary pulls a person out of poverty and is potentially life-changing for that person's entire family. At this point in time the benefits of a career in anesthesia are not shared equally among racial/ethnic groups.

The Health Resources and Services Administration (HRSA) released a report in 2017 that outlined the racial and ethnic diversity of various types of health occupations. The occupations in the Health Diagnosing and Treating Practitioners category (a category that includes physicians and advanced practice nurses) were overwhelmingly White or Asian. The Health Technologists and Technicians category (a category that includes surgical technologists and vocational nurses) has significantly more racial diversity, but these jobs require significantly less education and training, and carry less autonomy, professional respect and remuneration (HRSA, 2017).

The HRSA report does not collect numbers on categories in the aggregate, but since this dissertation is focused on advanced practice nursing, the nursing numbers are as follows: 84% of Advanced Practice Registered Nurses (APRNs) are white, while 5.7 % are Black, 4.5 % are Hispanic, 4.1 % are Asian and 0.2 % are American Indian/Alaska Native. Similarly, 74.5% of Registered Nurses are white, while 10.4 % are Black, 5.7 % are Hispanic, 8.4 % are Asian and 0.4 % are American Indian/Alaska Native. Moving down the nursing hierarchy further, we see that among Licensed Vocational Nurses 60.8% are white, 23.1 % are Black, 9.4 % are Hispanic, 4 % are Asian and 0.7 % are American Indian/Alaska Native. Among Nursing Assistants (the lowest rung of the nursing hierarchy), only 46.8% are white, while 32 % are Black, 13.7 % are Hispanic, 4.5 % are Asian and 0.8 % are American Indian/Alaska Native (HRSA, 2017). There is a place in nursing for non-Asian non-white clinicians, it would seem, but that place is not among the most highly-paid nor the most highly-respected (*see figure 1*).

The dominance of white culture in the United States cannot be overstated, and its influence on nursing and healthcare is pervasive. According to McGibbon, E., Mulaudzi, F. M., Didham, P., Barton, S., & Sochan, A. (2014), in a discussion of the *Decolonizing Nursing Project*, state, “Nursing knowledge continues to be grounded in Western biomedical hegemony...” As a simple example of this hegemony, “white” is often conflated with “normal” to such a degree that even routine nursing charting has listed “pink” as a normal skin color. (Lancellotti, 2008). This has been true for the majority of my nursing career.

Institutionalized racism is rarely acknowledged in nursing education, perhaps because nursing faculty are uncomfortable acknowledging issues of race and racism (Nairn, Hardy, Harling, Parumal & Narayanasamy, 2012). The nursing profession is seen as a caring profession, which may “...make it difficult for nurses to acknowledge racial prejudice within the profession.” (Barbee, 1993). McGibbon, et al, (2014) call nursing a “white institutional space”, describing an “...ideological frame that minimizes and denies the relevance of racism.”. Cottingham, M. D., Johnson, A. H., Erickson, R. J. (2017) discuss the difficulty of documenting racism within nursing, citing “...cultural analysis that attributed health care disparities to individual health behaviors while also attributing careworkers’ experiences of systemic racism to individual bias.” In other words, we tend to blame problems faced by people from minoritized groups on anything except the institutionalized racism that is probably largely responsible for said problems.

Gould (2013) opines that institutional effort to increase diversity is lacking, stating “Many higher education institutions (predominantly white) demonstrate challenges and problems with academic enrollment of minority students, in particular. There are some respected majority (white) institutions that lag behind with a nonexistent or poorly planned policy to address the

disparity in higher education.” We are seeing increasing efforts on the part of many professional groups and institutions regarding increased diversity, but unfortunately the demographic picture of nursing has not changed significantly since 2013, when Gould noted the paucity of institutional effort.

White people in the United States often see themselves as non-racial and color-blind, which ignores the continued existence of racial inequalities in our institutions (Holland, 2014). It is easy to consider yourself non-racial when none of the ramifications of race affect your day-to-day life. It is also easy to consider your success as merited and to hold the opinion that the success of others is similarly dependent upon their merit. Is it true, though, that merit is unevenly distributed among different racial and ethnic groups? I think we must strongly consider the possibility that some degree of institutional racism is affecting the occupational distribution of the healthcare workforce. Cottingham, et al, (2017) argue that “although the United States healthcare system positions itself as a color-blind institution promoting diversity, inclusion, and equal opportunity, the specter of racism and sexism within the American context remains.” The numbers are not lying to us. It is clearly the case that white people advance through the ranks of nursing more readily than do minoritized people. This implies that there are different artificial barriers to advancement in nurse anesthesia for people from different backgrounds. The best way to uncover those barriers is to ask people who have overcome them.

Although there are multiple groups of people who are underrepresented in nurse anesthesia, this work will focus on Black nurse anesthetists. A dissertation is, of necessity, limited in focus. The practical concerns of being a full-time faculty member, a health policy activist, and a doctoral student make placing constraints on the work a matter of necessity. Future work will involve other racial/ethnic groups as well as gender, socioeconomic status, and

sexuality. According to the United States Census Bureau (2010), Black people make up twelve percent of the United States population, but only three percent of nurse anesthetists are Black. It seems reasonable to address that discrepancy immediately.

Ogbu (2004) frames the dilemma facing Black people as a status problem. “Status problems are collective problems which members of the subordinate group find difficult if not impossible to solve within the existing system of majority– minority relations.” Ogbu (2004) delineates four types of problems faced by Black people in Western society: involuntary incorporation in society, instrumental discrimination, social subordination, and expressive mistreatment.

Historically, the enslavement of Black people forced large groups from their ancestral homeland and into societies where their status was that of property. This involuntary incorporation in society occurred hundreds of years ago, but as a culture we have yet to come to terms with the issues created by this mass kidnapping, torture, and forced labor. Ogbu (2004) asserts that Black Americans face a legacy of “enforced minority” that affects them individually and as a group to this day.

Instrumental discrimination, according to Ogbu (2004), involves the denial of access to jobs, education, and political participation. This work focuses specifically on the denial of education, and thus of jobs. It is my assertion that the racial distribution of the nursing workforce, outlined earlier, and the low numbers of Black people in the nurse anesthesia profession both stand as evidence that instrumental discrimination continues to plague Black people in the nursing profession.

Social subordination and expressive mistreatment, described by Ogbu (2004) respectively as “residential and social segregation, hostility and violence” and “cultural, language, and

intellectual denigration”, occur as microaggressions (and occasionally, physical aggression) against minoritized people. I will allow the voices of my participants to speak to both of these issues.

Ogbu (2004) further asserts that, “These four mechanisms are used by the dominant group to create and maintain the collective identity of the minorities; i.e., to ‘carve them out’ and maintain them as a separate segment of society with a distinct identity. The existence of the minorities with distinct collective identity remains as long as these mechanisms or mistreatment of the minorities remain.” Are there behaviors and/or policies that serve to separate Black nurses and nurse anesthetists from the larger group? It is important to remember that we cannot look at nurse anesthesia as if it exists in a vacuum, because the nursing profession is the pipeline to advanced practice nursing. If these behaviors or policies exist, are white nurses and nurse anesthetists capable of recognizing the behaviors or policies as problematic or is systemic societal racism so pervasive that we simply accept the status quo?

Individual racism certainly still exists, and must be dealt with, but it is systemic or structural racism that systematically marginalizes and excludes groups of people. Again, what “symbolic cues” are different groups of people encountering as they make the decision to pursue or not pursue higher levels of education in nursing within an institution that has yet to come to terms with its racially-charged past and its racially-charged present? Can we alter those cues to create a more inclusive environment in the short term, while working towards institutional change in the long term? This work seeks to answer that question and move toward a more inclusive profession.

Cultural Studies and Nursing

A unique aspect of this particular work is the utilization of a cultural studies lens to examine issues in nursing. I think of cultural studies as the examination of power relationships and resource allocation in various cultural settings, with cultural settings including such things as state/national cultural settings, institutional cultural settings, and casual cultural settings. A cultural setting is a group of people who share such things as language, rules for behavior, customs, mores, and beliefs. Nursing is a unique cultural setting with rules, customs and mores shaped by our history, our interactions with various stakeholder groups, and our interactions with one another.

Culture is an artificial construct. The rules and mores that we have created are often arbitrary (pink clothing for girls, blue for boys), based on sexism (men work for pay, women do the free “emotional labor” that is necessary to keep things running), or racism (Black people are athletes, white people are bankers and engineers). Shared traditions may be important to creating interpersonal social bonds, but they are equally artificial. Many of our shared traditions in the United States revolve around religious myths, although they have become more secular in recent years, such as Christmas and Easter. Others have to do with our view of ourselves as benevolent and harmless, such as the Thanksgiving myth which depicts the Pilgrims as sharing a peaceful meal with the Native American peoples they came to oust. These myths are the stories we use to collectively define ourselves, but they create a false picture that can be harmful to people who do not share the dominant culture. These myths of benevolence are further problematic when we assume our own behavior is above reproach.

Cultural studies examines the relationships between culture and power (Barker, 2012). In particular, Barker states that cultural studies scholars seek to “develop ways of thinking about

culture and power that can be utilized by agents in the pursuit of change.” I am absolutely, unapologetically, and resolutely pursuing change. According to the American Association of Nurse Anesthetists (2016), Certified Registered Nurse Anesthetists (CRNAs) practice in a variety of settings with a high degree of responsibility and autonomy and rate of pay commensurate with both. These jobs are highly sought-after, and entering the profession makes a drastic difference in one’s socioeconomic status as well as in one’s professional prestige. Nurse anesthetists remain predominantly white people (Rivera, 2017). This employment opportunity, lifestyle, and status change has been kept (wittingly or unwittingly), since its inception, for members of the dominant culture. That should be a source of consternation for the leaders and scholars of our profession.

Barker says (2012) that a leaning toward Marxism within cultural studies leads to an emphasis on the material, or economic aspects, of culture. I cannot deny that leaning on my part because I am a pragmatist and because I grew up in a very resource-poor household. Economic aspects are very important to me, as I have attempted to live without resources as a child and again as an adult. Such a life is stressful and frightening. The material benefit of a high-paying, prestigious, secure job is something that I see as being kept from minoritized candidates when I look at diversity within my profession. I may be accurately criticized for focusing too heavily on financial aspects of nurse anesthesia, but the ability to ignore financial aspects is a distinct privilege, and is a privilege that I have not always possessed.

Cultural studies scholars (aside from the ones already mentioned who focus on racial issues) to whom I will refer include Barker, Hall, Ladson-Billings, and Marx. They have created a legitimate framework from which to consider issues of equity and diversity and its connection to health and well-being. Barker (2012) cautions me to avoid biological reductionism, which he

says involves citing simple genetic or biological antecedents to behaviors, even as he admits that examining genetic or biological factors can help me discover what he calls “causal chains” in attempting to explain phenomena. I have never taken a reductionist stance with regard to health or wellness, though, and I think that is because the nursing paradigm, with its focus on holistic perspectives and patient care, leads away from such an approach. Nurses look at both biological and sociocultural factors related to health and well-being (Alligood, 2017), and I think I can make the argument that cultural studies is an excellent lens through which to examine sociocultural factors.

Michel Foucault wrote extensively about medical sociology in the 1970's and 1980's, but my reading of his work leads me to believe that he dealt more with the individual (that is to say, the patient) and his or her interaction with the healthcare system (Bunton & Peterson, 2002). In other words, medical sociology from the patient perspective, where the doctor-patient relationship was inherently problematic due to the marked imbalance of power between the two and the potentially devastating consequences of poor decisions on the part of either party. My focus is the healthcare workforce (specifically, advanced practice nursing) and the education of that workforce, so I am looking at nurses with a view toward understanding how and why we have created educational systems that advantage some groups over others. I think, though, that some of Foucault's ideas certainly apply. For instance, Bunton & Peterson (2002) report that Foucault saw a positive correlation between knowledge and power, such that one inevitably increased the other. Additionally, we must be mindful of the outsized influence the dominant culture in any profession has on valuing different forms of knowledge. Persons or groups who hold power can elevate the body of knowledge they control and possess, and devalue the body of knowledge controlled and possessed by a subordinate group. This serves to further entrench

power and resources within a dominant group. We often see this dynamic in nursing play out in our scope of practice battles with our physician colleagues.

I interpret Foucault as generally talking about official sources of power, such as governmental organizations, but individual and professional power relationships are as important as governmental power in our modern healthcare system, particularly where workforce development is concerned. If I apply that principle of interconnected knowledge and power to students, I can perhaps make the case that withholding advanced education from a group of people is a way of denying those people access to resources and to power.

Foucault also talked about the coercive and hegemonic nature of medicine (Bunton & Peterson, 2002). Again, he was talking about the interaction between the patient and the healthcare system, and he is correct. For instance, we use terminology such as “noncompliant” to discuss patients who do not follow a prescribed medication regimen, as if we have some sort of authority from which to insist that they comply with us. Is there any other service profession that would be allowed to act in such a manner? Would you allow your hairdresser to dictate your hairstyle and deem you noncompliant if you disagreed with their edict? Your mechanic? Your personal trainer? I recognize that the knowledge gradient between patient and healthcare professional is probably far greater than that between hairdresser or mechanic or trainer, but the stakes are higher, as well. A ruined hairstyle or a broken vehicle are not on par with a heart attack or cancer, after all. But Foucault makes a good point about the inherently coercive nature of modern medicine, and I believe that that coercive nature carries over into nursing education. I think some of his arguments, restated, might help me build my case.

For instance, in terms of clinical education - clinical preceptors are the nurses who teach nurses how to be nurses in the clinical setting. As such, they wield a great deal of influence and

power over student nurses. Clinical preceptors encourage or discourage words and behaviors as they shape the future practice patterns of the student nurse. If the student nurse fails to fit into the preconceived criteria specified by the preceptor, the repercussions can be severe, up to and including dismissal from the educational program (Happell, 2009). This coercion is often considered necessary, but how necessary is it? Preceptor coercion aimed at reinforcing white Eurocentric cultural norms in the guise of improving patient care may have a negative impact on students from minoritized groups who may not easily adapt to the cultural mores of the dominant group, and may further have a negative impact on the care provided to persons who do not share the white, Eurocentric cultural diorama.

Barker (2016) warns us that “language does not accurately represent the world. Rather it is a tool for achieving our purposes.” This reminds me of the importance of defining my terms and of structuring my argument in such a way that I do not further damage the standing of minoritized applicants in the eyes of nurse anesthesia faculty and administrators. The issue of diversity remains somewhat contentious in my profession and no good comes of antagonizing the very people who serve as gatekeepers for the profession.

Barker did not intend, I think, to advocate for mollifying the dominant culture. Rather, he is pointing out the ways in which the dominant culture uses language to reinforce its position and privilege. It is therefore extremely important for me to be cognizant of my own position and privilege, and to revisit my words frequently to reduce the damage they may inadvertently cause.

My research will add to the body of knowledge in nursing, with the addition of cultural studies as a lens with which to view many of nursing’s most pressing issues. A discipline that looks at the correlations and connections between culture and power with an eye to the dismantling of oppressive institutional structures and reconstructing a more just institution is

useful across the board, I think, and nursing has a history of being both oppressor and oppressed. As a female-dominated profession, nursing suffers from many of the same power dynamics that have affected gender roles for hundreds of years. There are unexplored power dynamics woven throughout the entire profession, many of which are certainly harmful to nurses and to the patients they serve.

Nursing is a veritable untapped cultural studies goldmine. A search of CINAHL and PubMed utilizing the term “cultural studies” and nursing or nursing education (quotation marks in the search engine limits search results to the specific phrase used) revealed fewer than 20 articles published over the last ten years. None were published in English-language journals and none were based in the United States. Care was taken to exclude articles involving cultural competence or transcultural nursing, because neither fully represent cultural studies concepts or methodologies. None of the articles published in the United States and only two published in other countries dealt with the scholarly pursuit known as cultural studies.

Nursing scholars in the United States are not utilizing cultural studies methodology to address systemic issues in nursing or nursing education. Nursing has come to terms with the idea that systemic issues are the underlying cause of medication errors and poor hospital outcomes. We need to come to terms with the systemic issues affecting our profession. This is an opportunity for cultural studies scholars to turn their lenses to nursing institutions, to nursing populations, and to populations served by nurses. An examination of power relationships and structural inequities in nursing institutions and nursing populations might help us in our call for meaningful change to make our nursing institutions more equitable. I believe this might allow us as faculty to do a better job of teaching students to provide equitable care to the populations served by nurses.

Purpose of the study

The purpose of this study was to conduct an exploration of the experiences of persons belonging to racial/ethnic groups that are currently underrepresented within the nurse anesthesia profession who have successfully navigated nurse anesthesia educational systems. These individuals, by virtue of their presence within the minoritized group of Black Americans and within the nurse anesthesia profession, are uniquely qualified to identify both individual and systemic issues that may have served as barriers to their progress through the nurse anesthesia educational system. They are also uniquely qualified to identify anything that assisted them during the process. The research, then, consisted of interviews with practicing nurse anesthetists who self-identify as Black and whose identity as practicing nurse anesthetists was verified by the researcher.

The research questions are:

1. What is the educational experience of persons whose racial/ethnic background differs from the racial/ethnic background of the majority of nurse anesthetists? Specifically, what is the educational experience of Black individuals in nurse anesthesia programs?
2. What factors helped these individuals as they progressed through their program of study in nurse anesthesia?
3. What factors were perceived as barriers to the successful completion of a nurse anesthesia educational program?

Understanding the experiences of individuals who have successfully navigated a challenging course of education may assist nurse anesthesia faculty, admissions committees, and nurse anesthesia professional organizations in creating strategies designed assist persons from

various backgrounds during the course of their education. This may help rectify inequities and should ultimately serve to increase the diversity of the nurse anesthesia profession.

There is very little research on the lack of diversity in nurse anesthesia. Although the research that exists on diversity in nursing as a whole is useful, individuals who self-select to pursue advanced education are going to have a different experience than those who obtain a nursing degree and remain working at the bedside throughout their career. Likewise, we can extrapolate some information from the research on diversity in non-nurse anesthesia advanced practice nursing groups (nurse midwives, nurse practitioners, clinical nurse specialists) but each nursing practice arena is unique. Each advanced practice nursing specialty has different admissions criteria, different requirements, and a different educational pathway. Conclusions drawn from research on one practice area may or may not be applicable to another, and thus it is prudent to examine each practice area individually. It is also the case that research on diversity in any advanced practice nursing field is limited.

This study seeks to discover elements that may hinder or help prospective nurse anesthesia students to successfully complete their course of study by examining the experiences of folks who have successfully completed a nurse anesthesia educational experience. The results will be generalizable only to nurse anesthesia admissions candidates. It is hoped that the information gathered in this study will be useful to nurse anesthesia faculty and to admissions committee members because we often think we understand the student perspective, but it is my guess that our understanding is limited. We don't know what we don't know about the educational experiences of persons from underrepresented groups, and nobody has asked anyone from those groups to recount their experience. We make assumptions about what we think we know, and those assumptions become part of our internal monologue. They become the stories

we tell ourselves, and the stories we tell ourselves inform our policy and procedures. This is particularly problematic when the stories lack accuracy. This research is an effort to rectify that lapse.

Definition of Terms

For the purpose of clarity in this work, the following definitions of terms are provided.

(Note: definitions of racial categories were obtained from the United States Census via the search function at <https://www.census.gov/glossary>.)

Acute care – a hospital or inpatient care setting.

Advanced Practice Nurse – a nurse who has completed a graduate degree in a clinical nursing specialty. This includes, in the United States, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Clinical Nurse Specialists, and Nurse Practitioners

African American – A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as “Black or African American,” or report entries such as African American, Kenyan, Nigerian, or Haitian.

Autonomy – The ability to determine the appropriate course of action in clinical practice and to act on that course as part of one’s scope of clinical practice.

Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black – A person having origins in any of the Black racial groups of Africa. It includes people

who indicate their race as “Black or African American,” or report entries such as African American, Kenyan, Nigerian, or Haitian.

Caucasian – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “white” or report entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

Clinical Nurse Specialist – A nurse with specialized graduate training in the diagnosis and treatment of illness in various populations. Clinical nurse specialists usually work in acute care settings.

Critical Care – An inpatient setting where specialized care is provided to individuals with life-threatening conditions who generally require comprehensive monitoring and frequent nursing and medical interventions.

Diversity – Composed of various backgrounds and races that comprise a community or group. The term acknowledges and appreciates the differences brought forth by each subgroup within the group.

Ethnicity – Refers to the social characteristics that people may have in common, such as language, culture, foods, and traditions.

Hispanic – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Individual Racism – the intentional expression of bias or hate based on race, directed at an individual or several individuals. This is generally expressed in the form of racial slurs or discriminatory behaviors towards the individual. *Also: individualized racism.*

Institutional Racism – racism expressed via social, political, and/or cultural groups. It is

generally expressed in the form of policies or norms, both explicit and implicit. *Also: institutionalized racism.*

Latinx – A gender-neutral term for a person who has a Latin American ethnic or cultural background.

Matriculate – To enroll in a program of study at a college or university. In this document, matriculate is used to refer to the beginning of a nurse anesthesia educational program, that is to say, when physical coursework begins.

Nurse Anesthetist – A nurse with specialized graduate training in the provision of anesthesia services to various populations.

Nurse Midwife – A nurse with specialized graduate training in the provision of obstetrical care to women and basic resuscitative care to neonates.

Nurse Practitioner – A nurse with specialized graduate training in the provision of primary care. Nurse practitioners often (but not always) work in non-acute care settings.

Race – refers to categories assigned to groups based mostly on collective, observable physical characteristics, such as skin color.

Registered Nurse – A nurse who has completed two to four years of training in a nursing program and who has passed the national certification examination for professional nurses.

Scope of Practice – the medical or nursing acts that a person with a specific type of medical or nursing license is legally permitted to complete.

Structural Racism – That system of institutional and public policies, both formal and informal, that perpetuate racial inequality.

White – A person having origins in any of the original peoples of Europe, the Middle East,

or North Africa. It includes people who indicate their race as “white” or report entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

I have chosen to capitalize the word “Black” in this document when it is used to refer to people who report African ancestral origins because capitalization recognizes that Black people share a common cultural heritage. I have chosen not to capitalize the word “white” when it is used to refer to people of Caucasian origins, because a similar shared cultural heritage generally does not exist except in subgroups of the white population.

In the next chapter I will discuss the literature available on diversity in nursing and in nurse anesthesia. In chapter three, I will lay out the theoretical framework and the ontological and epistemological considerations that molded my approach to the work followed by a discussion of the methodology for this project. I will describe my role as researcher and my positionality with regard to the material presented here. I will include information on institutional review board approval. In chapter four, the data will predominate, and in chapter five I will discuss the findings and my conclusions. I will end the chapter with recommendations for nurse anesthesia faculty, admissions committees, and professional leaders and with considerations for future research.

Chapter Two

Review of the Literature

In this chapter I will examine literature related to barriers faced by persons from underrepresented backgrounds in nurse anesthesia education. The literature on nurse anesthesia is scant, so I begin with a sample of the literature related to nursing in general, move to literature on advanced practice nursing, and complete the chapter with an analysis of the literature related to nurse anesthesia.

The literature search was conducted utilizing the Cumulative Index to Nursing & Allied Health Literature and PubMed. Search terms included: *advanced practice nurse, diversity, inclusion, nurse, nurse anesthesia, nurse anesthetist, CRNA, certified registered nurse anesthetists, education, minoritized, nurse anesthesia education, nursing education, nurse education, Black, African American*. Additional inclusion criteria were: peer-reviewed journals, publication in the United States and English-language publications. The latter two criteria were selected because nurse anesthesia practice varies widely in different countries and because the phenomenon of ultimate interest for this project is nurse anesthesia diversity within the United States, and so information from other geographic areas does not necessarily shed light on the situation in this geographic region. As noted, articles written in languages other than English were excluded, because the environment of interest is the United States

More than eighty articles were found that dealt with diversity in nursing. Excluded were articles dealing with the teaching of cultural competence to nursing students, as that is not a focus of this particular work. I also excluded articles dealing with culturally competent patient care. Culturally competent patient care is very important, but cultural competence in nursing should not be confused with cultural studies. Cultural studies calls us to examine cultural

constructs that benefit one group over another by distributing power and resources unevenly and further calls us to work towards a restructuring of those constructs (Barker, 2016).

Articles were then reviewed to select those that dealt specifically with diversity as it relates to nursing education. Twelve articles are included in the review related to nursing in general, there were no articles related to advanced practice nursing roles other than anesthesia, and eight were specific to nurse anesthesia. Of note, only one publication on diversity in nurse anesthesia is reported after 2014.

Nursing Literature

Nursing's Eurocentric underpinnings may provide a possible explanation for some of the challenges faced by minoritized students and for the lack of diversity within the profession. Eurocentrism, as described by Hassouneh (2008), is a view that frames European ideals as norms and frames ideals from non-European cultures as deviances from those norms. An article examined the Eurocentric model of nursing and demonstrated its use in marginalizing students of color. This model highlights the expectation of members of the dominant culture that nursing students will suppress their own natural tendencies in order to conform to the expectations of white nursing leaders (Southwick & Polascheck, 2014).

Eurocentric norms in nursing are the theme in an article whose authors speculate that faculty may be holding students inappropriately to white, female social and cultural norms (Debrew, Lewallen & Chun, 2014). The authors conducted a qualitative study of nursing clinical evaluation and posited that students feel the need to discard their own cultural identity in order to meet the norms presented by clinical preceptors (Debrew, Lewallen & Chun, 2014). The authors

point out that it hardly seems fair to ask minoritized students to give up their cultural identity in order to improve workforce diversity and reduce health disparities.

I found this theme of forced assimilation repeated in my readings in the non-nursing literature, as well. For instance, Wiederman (1985) states, “If you’re born Black in America you must quickly teach yourself to recognize the invisible barriers disciplining the space in which you may move.”. Olitsky (2015) says that dialogue with contemporary Black students “illuminates some of the ways in which seemingly ‘neutral’ practices, which are neither identified by the teachers nor their students as racist, end up contributing to racial segregation and stratification.” Treating all prospective students exactly alike, where “exactly alike” means expecting prospective students to conform to Eurocentric cultural expectations might contribute to segregation and stratification, even if one can honestly make the case that students are treated equally. Perhaps we want to reframe our view to urge that prospective students are treated equitably, where equitable treatment takes cultural differences into account. Derrick Bell might agree. In his words, “Decontextualization, in our view, too often masks unregulated--even unrecognized--power. We insist, for example, that abstraction, put forth as "rational" or "objective" truth, smuggles the privileged choice of the privileged to depersonify their claims and then pass them off as the universal authority and the universal good.” (Bell, 1987).

An additional issue with enhanced diversity may be found in an examination of the public view of nursing. High school students of any race may not be inclined to see nursing as a viable career. A study published in 2015 by Degazon, Natan, Shaw, & Erhenfield found that nursing students in the United States and Israel thought that nurses were hard workers but that the nurses lacked professional autonomy and that nursing lacked academic challenge. The students also

thought that nurses were underpaid with limited advancement opportunities. This highlights an image problem in nursing, perhaps partly due to inaccurate media portrayals of nurses.

A study of Hispanic/Latino college students found that these students have a level of interest in nursing as a career choice that is similar to that of non-Hispanic/Latino students, and that level of interest is generally low (Stroup & Kuk, 2015). Nursing may not be seen as a viable career by young people regardless of race or ethnicity. Attracting a diverse body of students in a low-interest environment may require creative recruitment strategies. The authors suggest outreach programs to engage student interest in nursing, allowing students to shadow practicing nurses, and promoting mentorship as methods to help students successfully enter and complete a nursing program.

Microaggressions were another topic that appeared in the literature. Microaggressions, according to Bellack (2015) are those subtle aggressive actions or statements that serve to oppress and dehumanize a marginalized group. She states her belief that nurses have good intentions but are often blinded to their biases and that this blindness results in actions that are not aligned with the nurses' intentions. These aggressive words and/or acts may make minoritized students feel othered and unwelcome (Hall & Fields, 2012). Bellack (2015) advocates the use of an assessment tool called the Implicit Association Test in order to reveal the unconscious biases held by the test-taker. The test-taker can then monitor his or her words and actions to determine if unconscious biases are affecting their behavior (Bellack, 2015).

An article close to home surveyed faculty teaching in baccalaureate nursing programs in Tennessee in an effort to gauge their level of cultural competence and then to correlate that level with the number of minoritized students who successfully completed the nursing schools associated with those faculty. This author utilized a cultural diversity tool that covered cultural

awareness, cultural desire, cultural knowledge, cultural skill, and cultural encounters (Ume-Nwagbo, 2012). The author suggests that higher levels of cultural awareness were associated with a higher number of minoritized graduates from the nursing program. The author further suggests cultural immersion as a method of increasing competence in nursing faculty. Travel to other countries and cohabitating with people of different cultures is recommended (Ume-Nwagbo, 2012).

The retention of minoritized students through mentorship was addressed in several journal articles. If a nursing program manages to attract minoritized students and subsequently creates barriers to their success, the makeup of the nursing workforce will not be affected to any large degree (Bellack, 2015). In 2014, Banister, Bowen-Brady & Winfrey surveyed students collaborating in a mentorship program for minoritized nurses and found that students who participated in the program had an attrition rate of zero (n=64). The authors of this study consider the following challenges: financial issues, linguistic differences, academic demands, isolation and loneliness, discrimination and racism, and lack of cultural knowledge among peers. The authors further report that those issues (challenges) tend to linger after graduation, with minoritized nurses feeling as if they constantly have to prove themselves capable to their employers and peers (Banister, Bowen-Brady & Winfrey, 2014).

In order for a school to successfully recruit and retain minoritized students, a structured program may be required. Diversity pipeline programs are helpful in recruitment of minoritized students, but nursing faculty and administration are often unsure how to best retain and support a diverse student population (Carthon, Nguyen, Pancir, & Chittams, 2015). It behooves us to look to successful programs as models for new recruitment and retention programs.

An article by Melillo, Dowling, Abdallah, Findeisen, & Knight (2013) introduces a program called Bring Diversity to Nursing that is one such program. This is a comprehensive effort in the state of Massachusetts to engage minoritized students early in their academic career. Minoritized nurses share stories of how nurses help people with elementary school children from diverse backgrounds. In middle school and high school these volunteers conduct workshops to introduce nursing as a career and provide mentors to help students successfully navigate their college preparatory courses. The financial aspect of nursing education is not overlooked - scholarships and stipends are provided to students in need. In 2007, the University of Massachusetts Lowell nursing program student body consisted of 12% ethnic and racial minorities, and by 2011 that percentage had increased to 20.2% (Melillo, Dowling, Abdallah, Findeisen, & Knight, 2013).

An article in *The Journal of Nursing Education* examined the experiences of Hispanic students. The author reports that apart from financial support, students from different backgrounds may need various types of psychological support as they navigate academia from the margins (Alicia-Planas, 2017). Feeling welcomed and connected to the campus community are both important to student success.

Duke University has established an entire program devoted to recruitment and retention of underrepresented minoritized students (Carter, Powell, Derouin, & Cusatis, 2015). Recruitment was targeted at universities with large populations of minoritized students, and early admission was offered to qualified students. This was followed by a summer intensive program to prepare students for the nursing school workload, and students immediately moved during the regular college session into a mentorship program designed to help them maintain their motivation level and meet programmatic requirements (Carter, Powell, Derouin, & Cusatis,

2015). Recruitment and retention of minoritized students improved as a result of these interventions.

Diversity in Nursing

Based on the demographic data currently available and a review of current literature, it appears that minoritized students might encounter barriers throughout their nursing educational journey. Nursing faculty need to ensure that they are practicing education with cultural awareness (Ume-Nwagbo, 2012). Nursing faculty also need to acknowledge and understand the effects of systemic racism in nursing education, and to encourage exploration of the faculty member's own role in perpetuating the system. Faculty members may feel defensive when facing their own role in a racist institution, so utilizing a non-threatening, non-blaming approach may help overcome that defensiveness and allow faculty to affect change in their practice.

Culturally aware practice includes self-reflection (paying particular attention to assumptions and biases), and self-education regarding the cultural backgrounds of the student population. Culturally aware faculty should pay attention to the educational environment, as well, and advocate for culturally sensitive policies and procedures. Nursing preceptors are clinical faculty who teach nurses at clinical sites and who may have more influence on students than didactic faculty (Happell, 2009). Preceptors essentially teach nurses how to be nurses, guiding students through clinical tasks and helping students develop sound clinical judgement (Happell, 2009). Thus, it might be important to ensure that clinical preceptors are culturally aware, as well, so that they do not hold students to unfair and inequitable standards. Continuing education for preceptors might be designed to address cultural awareness.

Mentorship programs were mentioned in the literature and seemed to have a high rate of success in minoritized recruitment and retention. Schools of nursing without mentorship

programs for minoritized students should consider developing such programs. Mentorship programs for new faculty from minoritized groups might also be useful to ensure that those faculty are welcomed and are treated in a culturally sensitive manner during their orientation.

Community outreach may be useful to recruit local minoritized applicants. Nursing students and faculty might engage in cultural studies projects designed to improve health in the community that houses the institution and thus bring awareness to the impact of nursing and to the various roles nurses can undertake. Inviting local high school students interested in health care careers to take part in projects with nursing students and faculty might allow prospective applicants to explore different roles within nursing. Assigning student mentors to local high school students might be beneficial to both mentor and mentee, because the process of mentorship will encourage the mentoring student to reflect upon what works and what doesn't work in terms of surviving the academic journey.

Ultimately, the goal of increasing diversity in an individual nursing program might be best served by forming a diversity task force of students and faculty from a variety of cultural and ethnic backgrounds. Because nursing schools vary widely in terms of policies, procedures, and educational processes, it is probably going to be difficult to develop a plan that would universally improve diversity on a broad scale. Certainly, nursing students and faculty need to advocate for social justice on a broad scale, but it seems that small-scale changes within each nursing program are likely to have the most impact on individual students. A task force of students and faculty from each school could examine the local political and educational climate, the school's student body, the school's recruiting pool, and the school's current policies and procedures. The task force could then make recommendations for a diversity enhancement program that suits the needs of their institution.

Diversity in Advanced Practice Nursing

A search of the CINAHL database using the terms *diversity*, *inclusion*, *advanced practice nurse*, *advanced practice nursing*, and *nurse practitioner* returned 116 articles. Excluding articles written in languages other than English, articles published in lay journals, articles set outside of the United States, and articles published before 2009 left 33 articles. All but three of those articles dealt with cultural competency in the care of patients. Patient care is critically important to advanced practice nursing, but a discussion of interprofessional diversity and inclusion really grapples with issues of professional socialization, of how nurses treat one another. The lack of inquiry into structural inequalities within the profession suggests that nurses do not necessarily perceive those inequalities. And yet, the numbers tell a story.

Program completion rates were an issue for Black students in one study (George, Munn, Kershner, & Phillips, 2018) that examined factors predicting success in a graduate nursing program. Fifteen Black students entered the program in question, but only three successfully completed it. Of note, the program's attrition rate was 41.7%. Of thirty five students who left the program prematurely, twelve were Black. This study was limited by the fact that only one program was examined, and that it is quantitative. The data suggest that there are barriers to minority student program completion, and the authors report a planned second, qualitative stage to the work in order to identify specific issues faced by various student groups. Creech, Cooper, Aplin-Kalisz, Maynard, & Baker, (2018) also found that race was a predictor of success in a Doctor of Nursing Practice program. They recommend targeted retention strategies for students from minoritized groups.

Poghosyan & Carthon, (2017) attempt to make an explicit connection between racial and ethnic health disparities and the healthcare workforce. They discuss both the racial/ethnic

makeup of the healthcare workforce and scope of practice issues. Advanced practice nursing scope of practice is often defined by arbitrary turf wars with physician providers and it is heavily politicized. These authors developed a nurse practitioner health disparities model which identifies barriers to and opportunities for optimal use of nurse practitioners in reducing racial and ethnic disparities.

Diversity in Nurse Anesthesia

Turning our attention specifically to nurse anesthesia, it was necessary to expand the timeframe of the search in order to accumulate any articles for analysis. It should be noted that the paucity of articles in total and the lack of publications after 2014 despite the lack of diversity within the profession arguably constitute a significant gap in the literature.

Four articles were published in *Minoritized Nurse*. Those articles were requested via Interlibrary Loan. It is interesting to me, however, that despite calls for diversity in nursing the medical library does not have a subscription to the only publication in the profession geared toward minoritized populations and diversity. Do we value diversity or do we not? Ultimately all four were included in the data analysis. This is not sufficient information to draw conclusions about anything, but it can inform my future research.

Six articles related to nurse anesthesia were included in the analysis (see Table 1). Six themes were identified in the articles analyzed. They are fairly closely aligned with the recommendations found during the review of generic nursing literature, which is not surprising. The themes are as follows:

1. **There is a need for increased diversity within nurse anesthesia.** The racial/ethnic makeup of the population does not match that of the profession. This was noted in each article. I have also noted it in the first chapter of this document. To be sure, there are clinicians who are of the opinion that diversity should not be a goal of leaders within the profession. I disagree with those people because if everyone has an equal opportunity to succeed, and if intelligence and ability are not tied to external characteristics, then the racial and ethnic makeup of the profession should closely mirror the racial and ethnic makeup of society. This is clearly not the case.
2. **There is a need for culturally competent anesthesia care.** That need can be partly met through better provider education, certainly, but it is also important to have diverse perspectives in nurse anesthesia research, education, and policy-making to help drive cultural competence. The need for cultural competence was highlighted in three of the articles. Although it is not a focus of my research at this time it is an area that does warrant further exploration.
3. **Students in anesthesia programs are intelligent but resistant to change.** They particularly resent what they see as “forced political correctness” – thus it is critical to get buy-in from current students as well as from members of the profession. This is one reason for compiling data to support the contention that the profession is not diverse enough, and that students from different backgrounds face different barriers. This group of students, clinicians, and faculty will pay attention to research. There is, however, not much research to which to refer them at this point.

4. **The pathway to a nurse anesthesia graduate degree is arduous and requires the completion of several steps in a set sequence.** This path may be challenging for folks from diverse backgrounds because they may have fewer opportunities to complete each step during the course of their education and career. This was discussed in two articles, and again, I have personal experience with which to back that contention. Our program requirements include a bachelor's degree in nursing followed by a minimum of one year in an adult critical care setting, and a competitive grade point average (usually a minimum of 3.5 is required to be invited to interview). After matriculation, the students spend thirty-one months in didactic and clinical training before they graduate and are permitted to sit for the certification examination. A misstep generally means the student must pursue a different course of education, because second chances are rare. All advanced practice nursing roles, including nurse anesthesia, are transitioning to a clinical doctoral framework. This means that programs will increase in length and it remains to be seen what effect the transition will have on various candidates. At the very least, program length (and, thus, cost of attendance) will increase.
5. **There are various strategies used by programs to increase diversity.** Some of these strategies, it goes without saying, are more effective than others. Such strategies include mentorship programs (discussed in two articles), and outreach programs (discussed in one). In one article the authors commended themselves for being located in an area with a diverse population and concluded that they were fortunate to be able to maintain strict enrollment standards.

6. **When program faculty made any effort to increase diversity, it was generally successful to some degree.** Four articles mentioned that faculty had successfully increased the diversity of their student body. Faculty actions and attitudes make a difference to applicants and students. This suggests that even small efforts may have big payoffs in terms of increasing the diversity of the profession.

One article by Gibbs and Waugaman (2004) contained a statement that was so egregious that I added a theme for questionable statements, but did not find any more such statements to include. I am going to quote the authors directly: “Whereas other nurse anesthetist programs across the country have focused their efforts on recruitment of minoritized students, XXXXX University, by virtue of being an international university in a multicultural location, naturally attracts a large number of diverse, yet qualified, applicants, and *admission has remained a highly competitive and selective process.*” (emphasis mine). This implies that other programs have had to reduce admission standards in order to attract diverse candidates. The authors provide no citation in support of this implication.

The assertion that minoritized candidates require lower standards in order to successfully matriculate into a program is both unfair and untrue. Unfortunately, when academic researchers hold the attitude that diversity necessitates reducing enrollment standards, those biases affect their research. The culture of a profession is built, in part, upon the knowledge generated by its researchers. When researchers fail to recognize and identify their own biases, harmful stereotypes persist. Since nurse anesthesia researchers are almost always also nurse anesthesia faculty serving on nurse anesthesia educational program admissions committees (Rivera, 2017), these biases may serve to impact admission rates for students from diverse backgrounds.

Critical Race Theory

Research on diversity in the healthcare workforce is important, particularly as the nation becomes increasingly diverse (United States Census Bureau, 2010). If very few people in the healthcare workforce share your culture and your perspective, your healthcare needs may well get overlooked. We simply don't know what we don't know about other people's experiences, and diverse teams may be able to act as interpreters for one another, giving us insight into our patient's lives and experiences, and ultimately allowing us to tailor care plans that suit each patient. Reading the sparse information available on diversity in my own profession and reflecting upon the lack of diversity I see around me every day brings the need for this work into sharp focus.

According to Ladson-Billings (1999), Critical Race Theory (CRT) is a derivative of Critical Legal Studies (CLS). CLS is a "legal movement that challenged the traditional legal scholarship that focused on doctrinal and policy analysis in favor of a form of law that spoke to the specificity of individuals and groups in social and cultural contexts" (Ladson-Billings, 1999). Ladson-Billings (1999), asserts that the CLS movement is chiefly concerned with the analysis and questioning of legal ideology as a method of legitimizing the social status quo, thus keeping America's "current class structure" firmly entrenched, but she concedes that "...CLS fails to provide pragmatic strategies for material and social transformation".

Bell (1995) tells us that most critical race theorists are people of color, noting that, "Those critical race theorists who are white are usually cognizant of and committed to the overthrow of their own racial privilege". I will depart from Bell's assertion just a bit with my own take on this assertion: while I am indeed very cognizant of my own privilege, I am not committed to the overthrow of that privilege but rather to the sharing of it. It should not be

considered “privilege” to be accepted into a profession once you have exceeded the academic admission requirements for that profession’s educational programs, to be welcomed into educational spaces when you have earned admission into them, and to have your perspective acknowledged. These should all be expectations of our learning and of our didactic and clinical spaces. We cannot build a more just and equitable future without facing our own part in it. I believe that it behooves all of us in nursing and in education to gain an awareness of our privilege with an eye to distributing that privilege equitably.

The style of this work is naturally heavily influenced by my own nursing and military background. Both disciplines exhort me to embrace brevity as an operational principle, to avoid belaboring a point, and to avoid the inclusion of extraneous material. In nursing and in the military, extraneous material is seen as potentially deleterious to the mission at hand. However, Bell (1995) asserts that “Critical race theory writing and lecturing is characterized by frequent use of the first person, storytelling, narrative, allegory, interdisciplinary treatment of law, and the unapologetic use of creativity.” The astute reader will no doubt be able to discern my struggle with this unfamiliar methodology as I continue to find my CRT voice.

The tenets of Critical Race Theory utilized for this work and pulled from the works of Crenshaw (1993), (Angela & Harris, 2002), and Bell (1995) include:

- **Permanence of Racism** – the concept that racism is endemic to our society and its institutions. The effects of racism are seen in everything from entertainment to politics to education.
- **Interest Convergence** – people of color only advance, according to this tenet, when their interests converge with the interests of those in power. This is seen

when scholars and politicians make the case for diversity based on perceived benefits to society as a whole.

- **Experiential Knowledge** – the knowledge possessed by people of color based on their lived experiences. This knowledge has been traditionally shared via storytelling and family histories. Experiential knowledge is the key to understanding the effect of institutional racism on students of color.
- **Intersectionality** – race intersects with other aspects of a person’s identity, such as gender, class, age, and disability to influence the lived experience of students of color. Additionally, racism intersects with other oppressive modalities such as sexism and homophobia.
- **Whiteness as Property** – the privilege of whiteness is a valuable asset, and white people act to protect that privilege.
- **Critique of Liberalism** – this is the process of challenging concepts of meritocracy, color-blindness, objectivity, equal opportunity, and incremental change.
- **Commitment to Social Justice** – the concept that all persons in a just society deserve security and equal access to resources.

Critical race theory will serve as both the theoretical framework and the methodology for this work. Critical race theory gives us “a way to understand and disrupt” racist institutions (Ladson-Billings, 1995). My goal is to amplify the voices and lived experiences of former students of color, and to eventually develop interventions that change the trajectory of the admissions and educational processes. According to Derrick Bell (1995), “most critical race

theorists are committed to a program of scholarly resistance, and most hope scholarly resistance will lay the groundwork for wide-scale resistance.” To which I say, vive la resistance! We do our cherished institutions no favors if we recognize fatal flaws within them and yet fail to take steps to correct these institutional flaws.

In an article published in 2014, McCoy used the term “extreme predominantly white institution”, which he defined as a predominantly white institution where students, faculty, and administrators of color are “significantly or grossly underrepresented; where the institution possesses a history of racism and exclusionary policies and practices; the local/surrounding community is overwhelmingly white; offers limited resources and/or services for people of color; and has no or few visible local communities of color.” If we substitute “profession” for “institution” we could certainly make the case that nurse anesthesia is an extreme predominantly white profession. Thus, it is reasonable to question if nurse anesthesia educational programs might also be considered extreme predominantly white institutions. Some of them clearly are.

Much of the life in today’s professional organizations occurs in virtual spaces. The American Association of Nurse Anesthetists holds three major meetings each year, but attendance at all three is challenging even for those of us who are very active within the association and who enjoy the relative flexibility of a career in academia as compared to a career blanketed by the regimented hours of an operating room. Most of the work of the association occurs via e-mail, message boards, and social media because in such spaces we can and do interact with one another daily. In accordance with Bell’s (1995) exhortation to engage in unapologetic creativity, I am envisioning spaces other than physical as “real” spaces where critical interactions occur. Therefore, I am going to include an examination of the social media culture of the association in this work.

I think Stuart Hall (1997) would approve of this characterization of virtual spaces as having meaning. He wrote:

“Popular culture is one of the sites where this struggle for and against a culture of the powerful is engaged: it is the stake to be won or lost in that struggle. It is the arena of consent and resistance. It is partly where hegemony arises, and where it is secured. It is not a sphere where socialism, a socialist culture -- already fully formed -- might be simply "expressed". But it is one of the places where socialism might be constituted. That is why "popular culture" matters. Otherwise, to tell you the truth, I don't give a damn about it.”

Virtual spaces are where the discussion that shape our actions as individuals and as a professional organization are happening. It takes weeks or months to disseminate ideas via conferences or journals, it takes seconds to disseminate them via social media, and responses begin to arrive in minutes. The conversation is dynamic and engaging, and in nurse anesthesia the discourse on social media has heavily influenced the activities of the professional organization, with both beneficial and harmful effects. It is certainly true that a scholar must sift through much more detritus when studying social media than when attending a conference or reading literature, but that does not make the content any less meaningful and influential. In fact, one might make the case that we have a responsibility as scholars engaged in social justice work to police the social media arena with an eye to providing critical counter-narratives to problematic concepts.

I have already spoken to the lack of diversity in nurse anesthesia earlier in this document. So, persons of color are significantly underrepresented. Some might argue that we cannot prove

that nurse anesthesia has a history of exclusionary policies and practices, but the history of racism is clear. For example, since its inception in 1931 there has been one Black president of the American Association of Nurse Anesthetists. As an example of the overt racism within the profession at present, here are some sample comments on a Facebook post (in a professional group whose membership is limited to nurse anesthetists and student nurse anesthetists) about diversity in nurse anesthesia education – names of posters are not included here to protect their anonymity. Their words are italicized and in quotes:

“What does diversity have to do with anesthesia? Especially now that white people call themselves Black, Europeans claim to be Native Americans and men call themselves women (and vice versa). It's become discriminatory to even ask these days.”

“Data collection will not show racial bias. I'm [sic] mean seriously...how many programs out there do you think aren't admitting people because of skin color?”

“Should we also study how overweight people are discriminated against? How about bald people versus beautiful flowing locks? Where does it end?”

“Forced diversity is always a bad idea. It decreases the overall competency. Those that should get in dont [sic] and those who shouldn't get in do. The goal should be finding out how to get the best and brightest of all races, ethnicities and sexes to apply and diversity will follow.”

“A massive new study, based on detailed interviews of nearly 30,000 people across America, has concluded just the opposite. Harvard political scientist Robert Putnam -- famous for "Bowling Alone," his 2000 book on declining civic engagement -- has found that the greater the diversity in a community, the fewer people vote and the less they volunteer, the less they give to charity and work on community projects. In the most diverse communities, neighbors trust one another about half as much as they do in the most homogenous settings. The study, the largest ever on civic engagement in America, found that virtually all measures of civic health are lower in more diverse settings.” It should be noted that Dr. Putnam holds the view that all of these issues are a result of the relative novelty of diversity in a very segregated society. In other words, they are symptoms of our fundamental disconnectedness and will only improve when we improve our level of connection. Dr. Putnam sees this initial reluctance to engage as a necessary step in the creation of diverse settings, so he rejects this anti-diversity characterization of his work (Putnam, 2007).

“If there is any racial bias, my guess is that Black or Hispanic applicants are favored over Caucasians because of all the white guilters out there.”

Even posters who are in favor of increasing the diversity of the profession tend to champion liberalism, as seen in this post:

“Increasing diversity in our ranks is achieved by being color blind when it comes to selection of faculty and students. Skills, education, and intelligence should be the means of determination of selection, not race, color, or religion.”

These comments are, by and large, written by people who fervently deny personal or institutional racism. The racism is clearly visible to the outside observer, but it is so pervasive within the profession that it is completely missed (or willfully ignored) by a substantial proportion of folks who post on this professional message board. This level of racial insensitivity is our professional norm. I draw the reader's attention again to the words of Stuart Hall (1997), "It [*note: popular culture*] is the arena of consent and resistance. It is partly where hegemony arises, and where it is secured." Today, social media is the arena of consent and resistance, and it is very definitely a significant site where hegemony is secured.

The poster in the examples noted above espoused merit as the primary criteria for admission to nurse anesthesia programs. This is an example of the myth of meritocracy. According to Kwate & Meyer (2010), the myth of meritocracy ignores the fact that resources are not allocated according to merit alone. They state "Thus, meritocratic ideology leads to policies that advance fewer allocations to help the disadvantaged, such as health care and welfare." I think we can make the argument that it also leads to fewer allocations of seats in academic programs, which hold the potential to bring individuals and families out of poverty due to the opportunity those seats and that educational experience provide(s).

Kwate and Meyer (2010) tell us that the folks who cling to the myth of meritocracy the most are also those for whom it is most harmful. They cite studies showing that poor Southern African Americans are often the largest endorsers of meritocracy. If you believe that hard work is the path to success, what does that say about you if you are not successful? Why would you fight for external change if you believe the problem is internal and that it is your own fault that you have failed to succeed? Thus, the myth of meritocracy can be harmful and dangerous.

The poster who suggested that admissions committees should be blind to color was (possibly inadvertently) practicing color-blind racism. Color-blind racism, while it seems harmless or perhaps even helpful, actually has the effect of suppressing the experiences and stories of oppressed people, thus allowing us to deny that oppression occurs (Martinez, 2009). The antidote to color-blind racism, in my mind, is counter-storytelling as advocated by critical race theorists. What better tool than CRT to justify the provision of counter-stories from students and faculty highlighting the struggles, abilities, and successes of students of color? I am learning that stories have a tremendous amount of power when advocating for change. Since qualitative research really is about stories (Elshafie, 2013) and since my project has a large qualitative component, the emphasis on counter-stories embedded in CRT makes it a particularly good fit for my research.

Critical Race Theory's claims of the permanence of racism are supported by the observation that racism is so pervasive that we simply do not notice it. It is part of the daily milieu, and it is less likely to be apparent to people who are not affected by it. I can correctly assert that I do not see racism in my everyday life, but racism is unlikely to be aimed at me. I cannot take my lack of experience of racism and extrapolate it to other people who do not share my racial and ethnic background. I could not even reliably do so for people who do share my racial and ethnic background.

One criteria by which we might evaluate nurse anesthesia is the presence (or absence) of resources for students of color. The only professional resource of which I am aware for students of color is Dr. Lena Goud's Diversity CRNA initiative (Gould, 2013). The Diversity CRNA program hosts workshops for nurses who are interested in nurse anesthesia education. These workshops are geared toward students of color but are open to anyone. Dr. Gould is doing

excellent work in preparing students of color for matriculation into nurse anesthesia programs, but that is only one aspect of education. What are we doing to support students of color after matriculation? I was unable to locate any professional resources for student support during the course of their education or during transition to practice post-graduation.

My assertion is that the examination of nurse anesthesia education through a critical race theory lens may lead to insights that might help the professional organization and nurse anesthesia faculty design interventions intended to support students of color so that they can become practitioners contributing to a more diverse professional workforce. Utilizing the search terms “critical race theory” AND “graduate nursing education” yielded no results. Nobody, to my knowledge, has conducted a qualitative study based on the tenets of critical race theory involving the experiences of graduate nursing students of color. By virtue of my education in both nursing and cultural studies, I can bring tools from one area to inform and improve the other.

Many arguments for improving the diversity of the nurse anesthesia profession utilize notions of the benefit to the profession as a whole, which we have already determined is comprised mostly of white people. That white people will benefit from the inclusion of people of color is a concrete example of interest convergence. One could also argue that making the connection between diversity and population health is also an example of interest convergence, because healthcare costs are ultimately distributed across the tax base via a complex method of reimbursement (Britton, 2015). Therefore, a share of the costs of poor health outcomes for any group are ultimately paid by each taxpayer. We all have a vested interest in improving population health.

A further argument for increased diversity involves the benefit of a wide range of perspectives when approaching the problems faced by the profession and by the patients we serve. According to Bell (1995), critical race theorists “seek to empower and include traditionally excluded views and see all-inclusiveness as the ideal because of our belief in collective wisdom.” It is true that I think we are better collectively, and that a multicultural profession is a strong profession.

As noted earlier, nurse anesthetists are well-respected and well-compensated professionals. Nurse anesthetists enjoy a great degree of professional autonomy. Keeping that prestige and wealth predominantly in white hands, which is the ultimate effect of all of our policies and procedures to date, is an example of whiteness as property.

The arguments against diversifying the profession include meritocracy. If people are truly qualified, the thinking goes, they will rise through the ranks and occupy the higher tiers of the profession. The fact that more people of color are not nurse anesthetists is cited as evidence that they lack the interest or ability (or both) needed to become nurse anesthetists. This circular argument would correctly be called logically unsound by a critical race theorist.

Chapter Three

Theoretical Framework and Methodology

In this chapter I outline the research questions that will guide this work, and I describe how cultural studies and critical race theory inform and influence the research design. I discuss participant selection, recruitment, interview questions, and data collection and analysis. I examine my role as researcher, describe my positionality and discuss biases and preconceptions. I also examine ethical issues and describe my application for institutional review board approval.

A qualitative inquiry is an appropriate way to understand and amplify the stories of students from underrepresented backgrounds. Qualitative research traditions align well with critical race theory's emphasis on experiential knowledge as a mechanism for "adding context to the objectivity of positivist perspectives" (Ladson-Billings, 1998). Are students of color experiencing marginalization and isolation during their educational experience? How would we know unless we ask the right questions? What strategies are students of color utilizing to navigate the mostly white spaces that make up their clinical and didactic education? How can we better support these students? To my knowledge, nobody has asked those questions to date.

Research Design

The purpose of this work is to examine the experiences of persons from underrepresented racial and ethnic groups who have successfully completed a nurse anesthesia educational program. Specifically, this work will examine the experiences of self-identified Black or African American individuals who have successfully completed a nurse anesthesia professional educational program. If we are to increase the diversity of the nurse anesthesia profession, it might be useful to explore the paths taken by folks who have successfully completed nurse

anesthesia educational programs. Understanding the experiences of people who are not part of the dominant racial/ethnic group that makes up the nurse anesthesia profession may help us increase professional diversity.

Research Questions

The focus of the study is the experiences of self-identified Black or African-American nurse anesthetists immediately prior to and during their nurse anesthesia educational program.

The following research questions guide this work:

1. What is the educational experience of persons whose racial/ethnic background differs from the racial/ethnic background of the majority of nurse anesthetists? Specifically, what is the educational experience of Black applicants and students in nurse anesthesia educational programs?
2. What factors helped these individuals as they progressed through their program of study in nurse anesthesia?
3. What factors were perceived as barriers to the successful completion of a nurse anesthesia educational program?

These research questions were addressed with a qualitative study that consists of interviews, field notes, and demographic information. Participants were free to discuss anything they wish during the interview, but I attempted to guide the conversation through a series of questions. Interview questions and prompts included the following:

1. Please describe your experience in nurse anesthesia education.
2. Please describe the admissions process.
3. Please describe any barriers you encountered during the admissions process.

4. Please describe anything or anyone that assisted you during that process
5. Please describe your anesthesia education.
6. Please describe any barriers you encountered during your course of education.
7. Please describe anything or anyone that assisted you during the course of your education.
8. Do you have any recommendations for faculty members and admissions committees that might increase programmatic diversity?
9. Is there anything else you would like to discuss before we close this session?

A qualitative design has been selected because it is my intent to allow the voices of participants to be heard, and the voices of people from non-majority backgrounds just do not appear in the nurse anesthesia literature. Cohen, Kahn, & Steeves (2000) suggested qualitative work as appropriate for allowing participant voices to predominate. I want to create a space that centers voices which might otherwise exist on the margins of the debate on diversity and inclusion in nurse anesthesia. Further, I want to understand the experiences of people from minoritized backgrounds and to begin to comprehend the meaning of those experiences. In this case, I am defining the majority and minoritized in terms of the proportion of members of each racial/ethnic group in nurse anesthesia. It is hoped that the experiences from their past can be used to make a better future for our students.

For the purposes of this work, historically marginalized populations are those who are excluded from accessing the full benefits of being a member of United States society by virtue of systemic racism and systemic oppression. Since this portion of the work is centered on race, I examine racial/ethnic groups that have perhaps not had equal access to nurse anesthesia

education. I begin with persons who identify as Black or African American because the work is necessarily limited for the purposes of completing a dissertation, and because Black or African American persons are the largest group of non-white nurse anesthetists. Since this is the initial project in a series of works, it makes sense from a pragmatic standpoint to begin with the group from which I am likely to get the most volunteers.

Decuir-Gunby, Chapman, and Schutz, (2019), in *Understanding Critical Race Research Methods and Methodologies*, suggest that we move the use of critical race theory from a “problem-posing orientation to a problem-solving orientation”. I interpret that to mean that they are calling for scholars to do more than just call attention to the problem, but also to work toward solutions. This call appeals to my pragmatic side, and so I find myself called to do both.

There is a need for educating faculty and admissions committee members about the experiences of people from historically marginalized backgrounds, and there is also a need to act in other ways to increase diversity within the profession. I hope to eventually use the data I gather to begin a discussion of practical modifications to nurse anesthesia education admissions and teaching processes to support the successful matriculation to and completion of nurse anesthesia educational programs by persons from historically marginalized backgrounds.

The population in question for the purposes of this work consists of individuals who identify as belonging to a historically marginalized racial or ethnic group that have successfully graduated from a nurse anesthesia educational group and who are gainfully employed within the profession. This reduces the risk that participants will suffer any retribution in the unlikely event that they are identified by some element of their story. Nurse anesthetists are currently in high demand, so while it may not be likely that an employer would be willing to lose a valued employee based on someone’s discomfort with that person’s stories from anesthesia school, I

cannot rule out the possibility that an anecdote might serve to identify a participant and subject that participant to some measure of professional retribution. Therefore, I have masked participant identities, gender, and geographic location and I have omitted several specific anecdotes from the written work.

Interviews using open-ended questions were used to elicit stories about the experience of each participant during the nurse anesthesia program application and interview process and during their didactic and clinical education. Participants were asked about both “barriers” and “boosters” – factors that either hindered or helped them as they navigated the path from nurse to nurse anesthetist. They were also asked for recommendations about best practices when interviewing and mentoring students from diverse backgrounds. I have outlined the common themes that emerged, and hope to use those themes to further the dialogue about increasing diversity within the nurse anesthesia profession.

Participants

The sample consisted of twelve individuals who self-identified as belonging to a non-majority racial or ethnic group. For the purposes of this study, the population under consideration was Black or African-American nurse anesthetists practicing in the United States. As previously outlined, the majority of nurse anesthetists in the United States are white. Thus, any individual who is a nurse anesthetist and who self-identifies as Black or African-American was a candidate for this study. Participant demographic data was collected but no participants were omitted due to demographic concerns other than race/ethnicity.

A call for participants was put out via social media using a Facebook page whose inclusion criteria requires proof of certification as a nurse anesthetist. There are more than

25,000 members of the group, each of whom has been credentialed by a group administrator. An additional call was put out via the general message board on the American Association of Nurse Anesthetists webpage. Each individual has been verified as meeting one of my criteria by a person that I know professionally and that I consider trustworthy. Individuals self-identified as meeting the race/ethnicity requirement. Recommendations for additional participants were solicited from persons answering the initial call for participants. This practice is referred to as snowball sampling.

Midway through the call for participants, I was contacted by Dr. Lena Gould, who wanted to discuss the nature of and motivation for my work. Dr. Gould is the founder and director of the Diversity CRNA program (Gould, 2013). Dr. Gould shared some of her personal experiences with discrimination and adversity during her time both as a student and as a professional. At the end of our conversation, Dr. Gould offered to reach out to past Diversity CRNA participants with a call to participate in this research. It is due to Dr. Gould's outreach that seven of my participants agreed to be interviewed.

Prospective participants were informed of the criteria for inclusion via e-mail after initial contact via Facebook Messenger or message board. Contact via Messenger/message board was limited to exchange of e-mail addresses and telephone numbers, if desired by the participant. Please note that participant e-mail addresses are visible on the professional message board, so they are not, strictly speaking, private. Any information participants volunteer via Messenger/message board was not included in data analysis unless the participant restates the information during the interview process.

Participants were interviewed via the University's Zoom account. Zoom is a secure platform for videoconferencing. As interviewer, I kept my camera on so that participants can see

me and hear my voice. Participants were given the opportunity to utilize voice-only or video and voice chat. All but one opted to speak to me on-camera.

Because this was a qualitative study set in a cultural studies framework, and because the aim is to elicit in-depth stories, twelve participants was assumed to be sufficient, particularly since twelve was the number of individuals who volunteered. Additionally, after coding the tenth interview, I realized that I was nearing saturation in that the same codes were coming up repeatedly. Future iterations of the work will use different interview questions and prompts in order to elicit more depth from participants. The data gathered in this work may also enable us to create a quantitative survey based on the themes unearthed in data analysis, but that will be a future project.

Methodology

For the purposes of this study, interviews of up to ninety minutes were scheduled and were conducted via the University of Tennessee Zoom account. Interviews were recorded and handwritten field notes were taken. Each participant was asked a question, given time to respond, and then the interviewer repeated an abbreviated version of the response back to the participant and allow for clarification. Extensive journaling of interview impressions was completed immediately following each session; this allowed me to capture my responses to the data as it was being created. I initially estimated that each interview session would consume about three hours of my time, this was a very optimistic prediction. In reality, I spent six to ten hours on each interview.

I maintained field notes and recordings on a password protected iPad that was locked in my office at home or at the university. Notes were backed up electronically to the University's

OneDrive, which is also password-protected. My personal iPad contains additional security features. If the iPad were to be stolen and the wrong passcode entered five times, all data is erased from the iPad. This feature is already present in the iPad because it is a feature of one of the email systems I utilize. It is impossible to disable this feature without deleting that email account, so it served as an additional layer of protection for the data.

Participants were connected to interview data by number only; the numbers will be randomly assigned to participants and the list of numbers and names is kept in a locked drawer in my office at the College of Nursing. Additionally, any identifiable anecdotal data that participants wish to exclude from data analysis was excluded, and this will be explained to participants at the beginning of the interview session. I further eliminated several disturbing anecdotes from the analysis due to the risk that the specificity of the anecdote might serve to inadvertently identify a participant.

Protection of Human Subjects

The proposal for this work was submitted to the Institutional Review Board at The University of Tennessee, Knoxville. No major risks were anticipated for participants in the study. Interviews were conducted using the secure Zoom video-conferencing services available to the University community. The interviews were scheduled at the convenience of the participants, who were informed that they could opt out of the interview or the study at any point up to publication of the data. Minor risks include the possibility of recalling memories of events that were unpleasant.

Participants were informed that they could refuse to answer questions or refuse to talk about sensitive subjects without fear of any reprisal. Any such refusal was accepted without

question. Likewise, if participants opted out of having their data included in the final analysis or if they requested omission from any future publication, such refusal was/will be accepted without question. Refusal to participate will be accepted up to data publication.

If subjects wished to be completely confidential during the interview process, I offered the use of an avatar in place of their video screen. The procedure for doing so was explained to each participant. Pseudonyms were used to identify participants during data analysis and writing, and pseudonyms will be utilized in all written records of the research. Any published material will also utilize pseudonyms. Gender and geographic location of participants will also be omitted from any future work. As noted earlier, actual names and associated demographic information will be maintained in a locked file. Actual names and contact information will be discarded no later than five years after the data analysis is complete. Institutional Review Board approval was a lengthy process, but ultimately the board granted approval for my study. Please see Appendices for a copy of that documentation.

Data Analysis Plan

The purpose of the study is to understand the experiences of Black or African-American nurse anesthetists immediately prior to and during their nurse anesthesia educational program, with an eye towards understanding factors that might have helped or hindered their advancement. Interview questions have been designed to elicit this information in the form of stories.

The goal of this cultural studies research is to understand the experience of participants in a possibly oppressive educational system. Utilizing critical race theory, we can assert that racism is endemic to institutions in the United States. Colleges and universities in the United States of America, then, are assumed to have racist properties. We have established that the professional

body of nurse anesthetists contains people who, at least occasionally, write racist responses. However, the interview questions are not written specifically to elicit accounts of racism, but rather to look at factors that participants experienced as aiding or hindering advancement within their educational program. It is likely that there are factors attributable to racism as well as factors unconnected to racism that helped or hindered participants.

Berry and Cook (2019) assert that people of color have multiple “lived experiences” – that they adapt to the dominant narrative while embodying a counterstory that connects to their racial and ethnic identity. I know that I have only scratched the surface of this counterstory in my initial work. I think that multiple iterations of this work conducted by people from varied backgrounds will be necessary to tease out the true counterstories my colleagues live every day. The stories that we tell ourselves frame our responses to our environment (Barry and Cook, 2019) and the stories that people tell about us may well frame the opportunities available to us. What stories are being told by and about Black students within our educational spaces?

I tried to be open to any information participants were willing to share. I think it is important to be cognizant of the fact that participant sharing may be more in-depth in future work, when a diverse team is on board. I think initial publications will also enhance trust as participants see that their voice is centered and that their experiences have been accurately rendered. This material must be handled well on the first iteration or later iterations will be at risk. This is a big responsibility, and one that I took very seriously.

Data from the interviews was organized into common themes, or codes. Coding was accomplished using Nvivo software and no predetermined codes were utilized. I ultimately utilized three coding cycles in an effort to look for patterns in the data. Codes were grouped into related categories that became apparent as the data was analyzed. Eventually the categories will

be further developed into concepts from which I can make assertions about some aspect of the participant experiences, but my sense is that I need to conduct multiple iterations of the work in order to make such assertions with any confidence.

Creswell (2007) discusses a method of data analysis that includes identifying researcher bias, developing a list of participant responses that are significant to the topic of the research, organizing those responses into themes, describing the experiential context, and synthesizing the phenomenological meaning of the event or phenomena being described. I utilized this method of analysis to guide my coding of the data because it makes sense to me.

Common themes in the experiences of my participants emerged, and I believe that those themes will lend some insight into systemic issues we have been unable or unwilling to address as a profession. Some of this failure probably stems from willfully ignoring issues raised by people from diverse backgrounds, but much of it is also likely attributable to ignorance. Nurse anesthetists and anesthesiologists like to say that clinicians who do not practice anesthesia “don’t know what they don’t know”. In this case, we need to turn that lens on ourselves as professionals and academics, and admit that we, too, “don’t know what we don’t know”.

Qualitative research does not always produce predictable results (Creswell, 2007). Participant responses are unique, though, and each response represents an event in the life of the participant. Common responses, as I said earlier, may point to systemic issues warranting further investigation. It is important for the researcher to consider any preconceived notions that may color the reporting of incidents described by participants. The research is intended to amplify participant voices, so the meaning the participant makes of the incident is ultimately what matters. Data summaries were provided to participants in order to verify that their experiences have been faithfully recorded and reported.

As described in the literature review, there is a paucity of research involving nurse anesthesia and diversity. There are a variety of appropriate ways to examine this complex issue, and I hope to help future researchers utilize a variety of lenses and methodologies. It seems most appropriate at this juncture, though, to begin the conversations with the stories of individuals with direct knowledge of the issue: those who have successfully completed a challenging course of study and who have done so as a member of a historically underrepresented group in nurse anesthesia.

An open-ended interview with guiding questions helped elicit focused participant stories. The interview questions are noted earlier in the chapter. These questions were only intended to guide the conversation. Participants were informed that they are free to discuss anything they like during the course of the interview.

Participants were free to decline to respond to any question and to stop the interview at any point. There was/will be penalty for refusal to cooperate at any point up to publication of data. The purpose of this work is not simply to collect data, but also to build trust so that future researchers can delve into the work and gain a deeper insight into the experiences of our colleagues. We may not know what we don't know, but we do not have to remain ignorant.

Role of the Researcher

I served as the interviewer, and thus was responsible for accurately recording the information provided by participants. I took extensive field notes during the interview and repeated the narrative back to participants to ensure I had captured their thoughts and their meanings. Interviews were also recorded using Zoom technology. It was estimated that each interview will take about ninety minutes with a further ninety minutes allotted for immediate

journaling. In reality, interviews lasted about an hour but I spent about two hours journaling each. I used recording plus field notes because it kept me involved in the process of the interview, and because having notes readily available helped me to reconnect with the participant to ensure that I had not missed any of their points. I found that I did not accurately recall answers in their entirety without listening and taking notes, the note-taking helped me actively listen to my participants and helped curb my impulse to create a conversation as opposed to an interview.

Traditionally, researchers have been warned to maintain objectivity in their interactions with research participants (Starks & Trinidad, 2007), and that is certainly the predominant nursing position on research. The cultural studies scholar, though, is asked to examine her positionality and her biases and preconceptions and to acknowledge the influence imposed by those factors (Saukko, 2003). In fact, I have come to see the influence imposed by my own positionality as part of the work. This work would absolutely be different in the hands of a different researcher. That is not a design flaw, though. Rather it lends credence to my contention that a thorough examination of this phenomenon is not possible without a multicultural team of researchers. Furthermore, I am not approaching my subjects as if they are a laboratory specimen, I am approaching them as a colleague who has had an experience that is different from my own. I am making an effort to understand the meaning behind that experience.

As a white woman I am a member of the group that maintains a majority among nurse anesthesia professionals. I have had all of the privilege afforded white people in the United States, probably in ways that have not yet even occurred to me because I think there is so much we do not know about the experiences of people from minoritized racial/ethnic groups. I nonetheless think it is appropriate for me to begin this work because nobody else is doing so, to my knowledge. There is a void, and into that void are being expressed all manner of speculation

by folks who inhabit the majority space and who have been taught that their voices are the ones that matter. We cannot make the case for change without establishing the need for change, and stories are powerful motivators.

In 2018, the AANA established a committee to promote diversity and inclusion within the organization. This committee was welcomed by some members, but other members were unhappy with the push to diversify. This selection of comments from a generic (that is to say, not subject-specific) organizational professional message board demonstrates the discord:

“No diversirty [sic] needed. Just the brightest minds, no matter race or sexual orientation.”

“‘Diversity’ is a code word for racism. I celebrate unity, regardless of differences.”

“So, if we want our profession to reflect the diversity of our nation, is there anyone prepared to demand that the NFL, NBA, and all sports teams also demonstrate that diversity? Anyone? Or do we only want the best and most talented athletes on the field...”

“Could it be that your ‘scholarly’ research is simply a bunch of left-wing propaganda? There is a ‘lesson’ you could start with. There is a backlash forming. It turns out that white people don’t like to be discriminated against more than any other races did. You should have seen it coming.”

This notion that increased diversity is the equivalent of racism against white people is very interesting. The implications of this line of reasoning have evidently escaped the commenters. After all, if one thinks white people will suffer because of a level playing field, perhaps one's opinion of their own abilities (and the abilities of their fellow white people) is not very high. Or perhaps they visualize success as a zero-sum game, that success is like pie – a finite resource? It is true that there are limited slots in any nurse anesthesia educational program, but it is also true that admission generally comes down to grades, intensive care experience, an essay, and an interview. Three of those things are well within the applicant's control, and successful interviewing is a skill that can be developed. If all things were truly equal, as the meritocracy advocates insist, the profession would mirror the racial and ethnic makeup of the population.

Some nurse anesthetists contended that diversity is only an issue because some of us insist upon talking about it:

“The need to interject race or inequity into every conversation is unnecessary.”

“Diversity was not an issue until the SJWs made it one.” (This poster is presumably using a derogatory term for people with progressive views. SJW stands for social justice warrior, and the term is not generally considered a complement.)

“As long as we keep score, the racial divisions will never go away. Merit. Period. As many have pointed out, they want the best at the head of their table.” (this poster is referring to an operating room table. We say that nurse anesthetists occupy the head of the table because we

manage our anesthetic with an anesthesia machine attached to the patient's airway, which is proximal to the top of the operating room table.)

"You should be looking at safety or clinical issues. This lefty work brings nothing of value and may even hurt the profession."

To be fair to my colleagues, there were several posters who expressed a different perspective:

"I fully recognize that I am where I am because many people helped me. Teachers, cafeteria workers, counselors, scholarships, government aid, bosses, coworkers, my schools and colleges... I didn't do it all alone and everyone should have the same 'help' I had. It definitely takes grit to come from nothing but it takes a strong community with resources to help as well."

"The issue is larger than our profession, It encompasses our entire nation. The lack of diversity is a symptom of the larger problem."

Although I find some of the comments on the message board problematic, it is encouraging to see that the nurse anesthesia community is beginning to engage in a serious dialogue about diversity. We cannot change without engaging in this dialogue. The dialogue is not going to be comfortable, but it is necessary. The wide range of sentiments aired on message boards and in conversations throughout the country need to be aired and evaluated. Our scholars have been largely silent on the issue, but this is our issue. These are our flaws and our dirty

laundry. Education is the domain of faculty and scholars. It is well past the time for nurse anesthesia researchers and faculty to speak up.

Following the creation of the Diversity and Inclusion Committee, on which I have served for three years, several committee initiatives were launched in order to start a conversation about inclusiveness. As a committee member, I published an opinion piece in the AANA News Bulletin asking that potential preceptors consider their implicit biases when working with students. A campaign designed to illuminate nurse anesthetists from diverse backgrounds was initiated. Committee members were cautiously optimistic that this might be the right time to push for change.

On March 2, 2019, it was announced that the keynote speaker for the organization's annual meeting in August was Dr. Jordan Peterson (AANA, e-mail communication, 2019). Dr. Peterson is a Canadian psychologist who has written a book on personal responsibility, but who has also made dubious claims about race and gender roles based on invertebrate studies and religious works, and about human parenting based on rat studies. I have never seen anything that I would consider racist attributed to Dr. Peterson, but misogyny and homophobia are a form of "othering" that has the same essential base as racism. The move was applauded by many of the members who held unfavorable views of diversity. I cannot state unequivocally that Dr. Peterson's selection represented backlash against the work of the Diversity and Inclusion committee, but as a committee member I can state that that was the general interpretation of my fellow committee members. There was a great protest, largely from nurse anesthetists who are members of the LGBTQ community, and ultimately the decision was made to replace Dr. Peterson with a less controversial speaker.

This is the professional backdrop against which my work is unfolding. Those of us with an interest in promoting diversity and inclusion are feeling pushback (as evidenced by the selection of comments, noted earlier) in certain professional settings, but we must not allow this backlash to stop our work. In fact, I think it is an optimal time to shape the conversation through narratives and discussions. We can amplify the voices of those whose experiences can highlight the difficulties faced by applicants and students who are not white, who are not cis-gendered and heterosexual, and who do not come from privileged backgrounds.

Beginning this work with Black nurse anesthetists is a deliberate choice because discrimination against Black people in the United States continues unabated. In the past year, at least ten citizens have filmed active racist acts committed against Black people by non-Black people (not always white, either) in various public settings. In my own workplace, several nurse anesthetists announced their decision to either purchase or sell real estate based on its proximity to Black neighborhoods, and not one Black nurse anesthetist is employed by the large academic medical center at which I base my clinical practice. Racism is not dead, and I have seen sufficient recent evidence of it to feel called to act.

I am humbled and honored by the fact that Black nurse anesthetists trusted me with their stories. I have opposed various acts of racism within the organization, and done so in visible ways, such as posting to the organization's message board. I serve on the inaugural Diversity and Inclusion committee of the national organization. I have a reputation as a progressive thinker and writer. I have made it clear that I am launching this work with an eye toward enlisting scholars from minoritized backgrounds to carry the torch forward. Still, I am a white woman operating from a position of privilege. I cannot change that, I can only acknowledge it and move forward anyway.

I am very certain that my race affected the answers I elicited from participants. This is why I believe it is critical to turn this research over to emerging scholars in future iterations. If scholars from similar backgrounds to the participants in my study get similar results, it will validate my work. If they do not, it would be interesting to try to parse out the reasons for the discrepancy, and that might be useful information when serving on an admissions committee, too.

My intent is for future iterations of the work to involve a multi-racial collaboration of researchers, and my involvement will be gradually phased out as researchers from varied backgrounds take over. A dissertation is necessarily the work of an individual, but this work really warrants a collaborative approach in order to gain the benefit of bringing to bear a wide variety of ontological and epistemological lenses on the issue. I want to get this narrative started and then hand it over to the people to whom it rightfully belongs.

It is profoundly unjust that marginalized scholars cannot take up this line of inquiry in their own right and have their voices heard and respected, but I simply lack faith in my fellow professionals and their ability to be objective around issues of diversity and inclusion, and my lack of faith is justified by the response every time the issue is introduced. I have a voice, and a metaphorical ladder. I can use both to amplify and elevate the voices of scholars from historically marginalized backgrounds so that they can tell their stories and help foment change.

I did not knowingly encounter any conflict of interest or ethical dilemmas during the conduct of my research. I am on faculty at the University of Tennessee, Knoxville, but my research is not connected to my academic role at this time because I serve as the chair of the Doctor of Nursing Practice program. Until recently, I served as Associate Program Director of the Nurse Anesthesia concentration, and I continue to serve on that admissions committee, but no

participants in this research will be program applicants because they will have already completed an educational program.

As mentioned earlier, I currently serve on the Diversity and Inclusion Committee of the American Association of Nurse Anesthetists (AANA) but receive no financial compensation for serving. The Diversity and Inclusion Committee is charged with examining issues of diversity within the profession and with encouraging increased diversity within the profession (AANA website, 2018). This dissertation is consistent with that mission, but the research is not being funded or influenced by the AANA. Research participants are likely to be members of the AANA because approximately 94% of nurse anesthetists are members of the professional organization (AANA, 2018), but my role within the organization is as a fellow member. I do not currently occupy a leadership role within the national organization and will not pursue one until this research is complete.

It is clear that this research is timely and important. I have covered the need for the work, the scant literature available on diversity in nurse anesthesia, and some of the attitudes of nurse anesthetists about diversity and inclusion. I have shared my positionality and my potential biases. I have described my intended methods to address the issue.

In the next chapter of this document I will allow the data to predominate. The words of my participants are insightful, self-aware, and frankly, troubling at times. They condemn an educational system in which racism and discrimination is allowed to exist but in which students must constantly be on guard.

Chapter Four

Data and Findings

In chapter three the methodology for this project was outlined. However, my Army drill sergeant used to say that no battle plan survives the battle. I thought I was going to hear stories of discrimination and exclusion, and I certainly did. But I also heard stories of strength, and hope, and self-affirmation. I think it is important for us, as program faculty, as members of admissions committees, and as clinical preceptors, to hear both. In this chapter I attempt to center the voices of my participants and to allow their words to speak for themselves. I have learned from my interviews that our students are remarkably resilient, but I will make the case in chapter five that they deserve better from those of us who teach them.

Participants

This study consists of interviews with twelve practicing clinical CRNAs who self-identify as Black or African American. Participants were located via notices on a professional social media page and the professional organization's message board. Eight participants were female and four were male. Interviews were conducted using Zoom technology OR the telephone, depending upon participant preference and comfort with technology. All interviews were recorded with the permission of the participants.

Participant names have been changed to random letters in order to protect participant privacy. Geographic locations will not be identified and gendered pronouns will be omitted in order to help protect the identity of participants. Quotes will also be randomly attributed so that coworkers and employers of participants cannot determine a participant's identity based on the sequence of experiences related by any individual. This may seem like an overabundance of

caution, but the anesthesia community is very small, and the community-within-a-community that is the Black anesthesia community is smaller still. Relating a series of events from one participant increases the risk of discovery, and so it was scrupulously avoided in this work.

Interestingly, participants framed their experience in a variety of ways even when faced with similar situations. Some were clearly traumatized by the experience, and some report that they have yet to recover from that trauma. Others chose to frame their experience in terms of “rising above” discrimination and racism. Some chose to ignore issues of race and ethnicity completely.

I entered into this work with an eye toward identifying barriers and assistors to nurse anesthesia education experienced by Black nurses, and to obtain suggestions to increase programmatic diversity from people who had successfully navigated the system. I found all of the above. I will endeavor to present participant stories in a way that protects their anonymity but that lays bare the experiences that shaped their course of education.

Interview data was transcribed by a transcriber. I reviewed the transcripts and listened to the interviews again while checking the transcripts again for accuracy. Finally, I coded the data set three times, allowing codes to evolve as I engaged the words. The codes identified were grouped into broad categories: Resources, Exclusion, Hazing, Inclusion, and Significance.

In the Resources category, the themes identified were: awareness, navigating the system, and funding. In the Exclusion category, the following themes were identified: segregation, I don’t belong, proving. In the Hazing category, identified themes were: misidentification, mistreatment, coping strategies. In the Inclusion category, the themes included: representation, mentorship, outreach. In the Significance category, the key themes were: recognition and

purpose (see Table 1). I am addressing the categories and themes in the order in which they impacted the student experience.

Table 1: Categories and Themes

Resources	Exclusion	Hazing	Inclusion	Significance
Awareness	Segregation	Misidentification	Representation	Recognition
Navigating the system	I don't belong	Mistreatment	Mentorship	Purpose
Funding	Proving	Coping strategies	Outreach	

Resources

The first category is Resources, because without knowledge and funding, graduate education is not within reach. The first theme in this category is awareness. Awareness is defined as knowledge of the existence of the nurse anesthesia profession. Several participants reported that they simply did not know that nurses could provide anesthesia care.

M: My mom went to nursing school, you know. And I think there was one assignment that she had that said, look into advanced practice careers and nursing. And she had to look up nurse anesthesia and then she talked to me about it. And that is the literal only reason that I even knew about that career path. Um, yeah. But I hadn't heard of it before that.

T: I've just honestly lucky to have even found out about the career itself. Um, I wouldn't have known anything about nurse anesthesia had it not been for my aunt who is also a nurse.

Navigating the system involves knowing the path: you need solid high school grades, and then you must obtain a Bachelor of Science in nursing, and you must maintain high grades as an undergraduate. This is followed by a minimum of one year working in an adult critical-care setting before you are eligible to submit an application to a nurse anesthesia program. Some prospective applicants may not find out about nurse anesthesia as an optional career path until they have already taken college coursework. If a prospective applicant does not understand the importance of earning solid grades, particularly in science courses, they may derail their chance at an anesthesia career before they even start the process.

R: I just didn't know. I spent two years in a neonatal unit and then I found out that nobody accepts that, even though it is more intense than working with adults. Much more intense. It didn't matter, I had to go back and get some adult experience.

N: I didn't have the grades. I wasn't a bad student, but I did not care about grades. I had to take some classes over again just to prove that I could manage that workload.

L: It just sounds so stupid now, but nobody ever told me that my grades mattered.

Finances are an issue for a lot of nurse anesthesia students, because the rigors of anesthesia education make it nearly impossible to work while you are in the clinical portion of the program. It really is a privilege to be able to afford to take nearly three years out of your working life to pursue an advanced degree.

O: You are seriously privileged if you have family who can help support you while you are in school. That's not a race thing, that's a normal thing. Not too many of us have that luxury.

Y: Funding is always an issue. You want more diversity in anesthesia? Find some money.

C: I didn't know how to budget, how to plan. I didn't understand costs and loans. I pretended I understood, because everyone else just seemed to get it, you know? Funny, I was never afraid to ask clinical questions but I was petrified of asking financial ones.

Exclusion

Exclusion is the second category of themes identified. Participants reported experiencing exclusion before and during their anesthesia education. To be excluded is to be left out, to have entry denied to you. The first experience of exclusion by participants was often exclusion from employment in intensive care units. Segregation of intensive care nursing units is a serious issue, and one that I had not encountered prior to this series of interviews. I honestly did not realize that that was a problem faced by prospective applicants, and I have served on a nurse anesthesia admissions committee for the past nine years. How many nurse anesthesia faculty are aware that this might be an issue facing prospective applicants? I do not know of any studies examining

intensive care unit segregation as a phenomenon. Intensive care nursing is a required prerequisite for nurse anesthesia programs, so excluding nurses from intensive care jobs bars them from submitting an application to anesthesia school. It is a form of gatekeeping and we cannot, at present, quantify the impact of it.

J: Well, one thing is get people to be able to get jobs in the ICU. You know, if you can't even get into the ICU, you can't even get the requirement or the qualifications to even apply. It just starts that simple, you see. Why are they, why are they segregating the ICU?

K: I know nurses who cannot get a job in the ICU. They've worked the floor for four, maybe five years. No opportunity, so they can advance in another specialty, nursing specialty, but they can't go to anesthesia school.

ICU job segregation is not an issue that occurred to me when I began this work, as noted earlier, but four of the twelve participants mentioned it as a potential barrier. It would be an extremely effective barrier, because there is no allowable substitute for adult intensive care nursing experience. This standard is enforced by the accrediting body for nurse anesthesia educational programs, and programs are not permitted to waive the requirement for adult intensive care experience. It is a solid gate.

The second theme identified in the category of Exclusion was I don't belong. Seven participants reported feeling that they did not belong in their nurse anesthesia educational program.

L: ...it's the white girls club. That's what I, and you know, like when I, I'm just being honest with you, I used to say to my friend, you know, it's really the white girls club. We don't really supposed to be here.

H: They just didn't want me there and I know it.

B: ...just knowing that my classmates felt like I didn't belong, that we didn't belong. That's an added stress that you just don't need.

Participants reported that they still often feel like they do not belong, in some cases even after several years of working in the nurse anesthesia profession. This is troubling because clinicians who do not feel confident that they belong in a profession might be less likely to consider serving as mentors to other people from their racial/ethnic background. Thus, the lack of diversity serves to perpetuate itself.

C: No, they don't want me there. They never did. And it still exists when you, when you come, you come to work. It's just different. It still exists, you know, it still happens at work, you know.

L: You're left out of get-togethers, and people look out for each other but nobody looks out for you.

E: I still am the last to get a break, the last to get lunch. I'm the only Black CRNA on staff, and nobody says anything overtly but I can see the board every day. I am not blind.

R: We have our own social media, you know. You won't see it, you don't know it's there. A lot of us stay off of the main social media pages for CRNAs. It's toxic, that ugliness, and it spills over into the meetings and into the workplace. And, frankly, it makes me want to stay away. Why should I give the AANA money and go to a meeting where I am not welcome? And it is clear that I am still not welcome based on some of the remarks by board members and AANA staff.

Proving is seen as necessary, in the sense that participants felt the need to prove that they were competent enough to be in a nurse anesthesia educational program and to eventually join the nurse anesthesia profession.

J: We were told, "You've got to be two, three times better than anybody else if you think you are gonna get out this program." My classmate didn't listen. And she didn't make it. She did not make it. And what they said, they would offer to pay for another program. But who's gonna take her? Yeah, who's gonna take her? I don't even think to this day she's a CRNA. And she was a nurse, but she also had a science degree. So, she was very smart, but they just picked on her, they picked on her.

L: And they disrespect... and that's another thing, the Black anesthesiologists, they get disrespected too. Don't think because you're a doctor... oh no, you are gonna get it. You are gonna get it. Yeah, that's pretty much it. You definitely feel like you've gotta always come with your A game.

E: Like you have to live up to something and you're a representation of your entire group and maybe you mess up bit. Oh well that must mean that, what? People of color aren't good at this. But when other people mess up, you know, it's just that one person. So, yeah.

Nurse anesthesia education is, by its very nature, grueling and stressful. Added pressure to represent your entire race every day is a burden students should not have to bear. One participant, however, reported an unexpected benefit from the effort to prove that they were capable:

D: I guess once I made it to my senior year, I got so many compliments. I think I had to be good, well, because I was so scared, I made sure I was doing everything right. Well, what happened was when that whenever somebody was with me there, they would say, "Oh wow, the other people don't do all this." And I'm just like, like, "I just try to make sure everything is right."

Hazing

The next category of themes is Hazing. There is some overlap between themes coded as examples of Exclusion and themes coded as examples of Hazing, but in general I tried to separate overt acts into the Hazing category while covert acts of omission were considered examples of Exclusion.

Misidentification is defined for the purposes of this study as the assumption that someone in a professional role is actually serving in a technical or support staff role. You may recall that nurse anesthesia students are professional registered nurses before they are allowed to begin their anesthesia education, thus my characterization of their status as professionals. Misidentification

was a very common theme during interviews. Misidentification may or may not be deliberate, but it serves as a continual reminder nevertheless that patients, family members, and even hospital staff perceive the target of misidentification as “other”.

T: ...what is it you do here, you know, um, are you a janitor? You're not an orderly? I'm not knocking any of those professions.

S: If I'm up here doing stuff, they always think I'm the tech or something.

J: For health staff, I can't count the amount of time I've been here, and people are like, oh, what are you here for? You know what I mean? Like they do not see people of color as someone who could take care of them competently. So that is a struggle too.

L: There was one housekeeper at my clinical site and she was just my cheerleader. She would tell me how happy it made her to see me climbing the ladder. That really helped when things got tough, just knowing that somebody was on your side.

Y: You're here to do what??! Where's the doctor?

Mistreatment refers, in this case, to inappropriate actions by others targeting the interview participant. Many of the stories shared involved specific clinical institutions, and given the size of the CRNA community it is important to maintain confidentiality. Specific stories with identifying details were omitted.

L: So it, it's been really, really rough and I had PTSD. Diagnosed with it.

U: I had a family member hospitalized and on a ventilator. And my classmate had a family member in hospice. She got extensions on her assignments and I did not. Why? They could not give me an answer. Could not give me an answer.

H: I learned later that this group would select a "victim" every semester. And it was usually the person of color in a group, but if that group didn't have one, they'd just look for weakness. And they would just pick, pick, pick at everything. Trying to break you down, make you quit. And when my semester was done, they moved on to a guy. And he did quit. And they were so nice to me after that awful semester, but I never did let my guard down around them.

S: And my ancestors took a lot, and I come from a strong people. I shouldn't be goin' through this, but guess what? I'm goin' through it. At least I'm able to live a decent life when I walk outside of there.

T: We just want people to know, like that's not cool. Right. They shouldn't do people like that. Nobody deserves to be mistreated just to get an education and to better themselves.

J: One day was just really, really bad. I couldn't do anything right. I was walking wrong, I kid you not. And then that evening I had an anxiety attack and I called my doctor. And she didn't even need an appointment, she knew. And that was the start of me going on antidepressants.

K: But at one point I really felt like I was starting to go down the drain because I just felt like this was this horrible. And why? I just kept saying, why, why do they treat us like this?

S: Would I advise my child to pursue this profession, in spite of all of it? Yes. Yes, I would. Because at the end of the day I have a very good life, and I have found a good practice. They appreciate me and I appreciate them and we work well together. But I would hate to have to relocate, just bein' honest. I really would. I would just be - stress all over again.

Coping strategies refers to methods used by the participant in response to hazing, such as misidentification or mistreatment. Some coping mechanisms have been discussed in conjunction with incidents already described. Asserting one's identity can be a coping mechanism:

N: Oh, I started wearing braids and everything, you know, to school. I was like, I want you to know I'm Black and I'm proud that I'm Black and you're not going to make me feel bad and you're not better than, you are not better than me. You know? So yeah.

G: I finally decided they were goin' to do what they were goin' to do. And I said to myself, let them bring it. Let them bring it. I am over this. And I stopped trying to impress them and I let me out of that box. And it was fine. It was fine. But I would not have dared to do that early in the program, I would have been kicked out.

Medication was an all-too-commonly reported coping mechanism. One participant reported that they could not enjoy anything during the course of their education due to the levels of medication needed to cope with the trauma.

H: You don't even laugh no more because you're so medicated and so stressed.

P: I had to take anti-anxiety medicine during the whole course of my clinical training. I thought I had come from a challenging unit but I did not count on the constant scrutiny, whew.

O: You know, I don't need medication anymore. About three months after the program ended, I stopped. Haven't needed anything since.

Inclusion

Inclusion refers to being accepted, being included. Participants did not report experiences of inclusion very often, but every participant mentioned wishing their program and/or the profession as a whole was better at inclusion.

E: That's all it is. No, nothing special. And that's the thing you hear about Black people. We don't want nothing too special. We just want the same as everybody else. That's it.

G: That's as it should be, you know, the same as everybody else. That's just fairness.

Representation was reported as an important aspect of inclusion. Seeing people from backgrounds similar to their own in professional roles within an institution was reported as a positive experience.

W: This is something we're looking for... When I was applying to nursing school, when you go onto [redacted] website, in your face like, we welcome diversity. It's one of the pillars of our school and it's full of pictures of you know, diverse looking students so you get a thought and feeling of "Okay I'm wanted here, I'm welcome here." So even just talking about diversity on your, you know having photographs of your classes and your students where they see that not everybody looks the same. I think that's a good starting point.

E: Just make sure that when you're doing the PR part that you are representing all men, women, and different groups from each racial background. It really is that easy.

J: When you visit a website and you see a wide variety of races and ethnicities it is reassuring. You think that maybe it's a place that is welcoming. A place you might be welcome.

Several participants spoke of the importance of mentorship. A mentor is someone who guides and advises a student or applicant. Participants who had mentors described their experiences in terms of overcoming or empowerment. Most report that they engage in mentorship themselves.

L: There was one Black nurse anesthetist at this clinical site, and she took me under her wing, you know, and she would tell me what supplies I needed, and which surgeons had what quirks, and what the anesthesiologists were known to ask. And it just took that stress down to a manageable level. I just wish every student had somebody like that. We'd be a much kinder profession, if they did.

S: Let me tell you something. All my professional life, the majority of my professional life, I've been the only Black person. But let me tell you something, I came from a poor background just like you baby." And I said [to a prospective student - author] "You can do it the same way I did it, you can do it." I said "I came from a single mother, I was divorced and a single mother." I said "You can do it. You just as smart as anybody else. Don't you ever let nobody tell you that you are not smart. You are. You are smart."

T: I try to mentor students as much, as often, as I can. We have to build them up to counter that beating down.

Outreach was mentioned as a potential recruiting strategy and as a way to let prospective students know that your program welcomes people from diverse backgrounds.

F: That Diversity CRNA program – that's a really good program. Do you know about it? Where they bring in nurses and talk to them about what it takes to be a CRNA? But it needs to start earlier. High school. Maybe junior high school. Let those babies know they

have options. They do not have to settle. There are good professions open to them. Why aren't we reaching out to high schools more?

L: What outreach do you do, your program? Do you go out and talk to people from various backgrounds? That would make a difference. You'd get results. Reach out to people, they listen.

One participant worried that the focus on diversity might have unintended consequences in the form of further division:

K: While I think that even the diversity thing that they have going on with the AANA is important, I think it just causes us to be more divided than anything because people who are already thinking that you're getting in because of your minoritized background or whatever, it's going to reinforce those beliefs and cause us to be more divisive.

Significance

The final category of themes is significance. Significance in this case, is the weight that participants gave to their experiences. How did the experience shape their views of the profession and of education? Recognition is the first theme from this category. Participants recognize that their experiences were problematic in many ways. Participants want their experiences to make things better for future students.

R: You really don't think about educating yourself and you know, going back to school and all these things, you're really thinking about surviving. That's not a connection you

make. So you don't, it's not the same. I think we have to make people realize that this is a problem and, and why it's important to change it.

***D:** We already know stress is physically and mentally debilitating. We know better than anyone how to reduce surgical stress, don't we? Don't we? We do that every single day. Why can't we apply that, that knowledge, that skill, to our profession? We should be doing everything we can to reduce stress on students and on people applying to programs. That's not to say it should be easy. I would never support making this easy – it's too important. People's lives, people are depending on us. But challenging is one thing, and deliberate stress is another.*

***L:** I don't want anyone else to have it hard, like I did. I want them to work hard, I don't mean that. Work hard! You know? I want them to study hard. But I don't want them beat down like I was, because it is just not right to treat people like that. It is not right.*

***G:** How'd a caring profession get so mean?*

The final theme in this section is purpose. Some participants have gained closure or satisfaction from volunteering to help student nurse anesthetists or applicants to nurse anesthesia programs.

***W:** You pay it forward. That's what you do. I have participated in the Diversity CRNA sessions and I am a friendly face to students in my hospital. Oh, and I tell the orderlies*

and the techs and the nursing assistants that I started where they are. I started where they are. You don't have to stay there.

T: It's my job, now, to make things better for the ones coming up behind me. We can make it better.

Conclusion

This chapter summarizes the rich data I obtained from my interviews. I asked eight questions and then allowed participants to talk about any topic of interest, for as long as they wanted to talk. One participant confided that he had been unwilling to participate until he spoke to other participants and received reassurance that my intentions were good. I am starting to build trust with my colleagues from various racial and ethnic backgrounds but this work really needs to be conducted by a team of scholars from different backgrounds. This will help us gather more robust data and help us analyze it from a variety of perspectives.

There are, unfortunately, things that I do not know I do not know. My experiences do not encompass the entirety of nursing and anesthesia education, and I have done both within a culture that caters to people who look like me. I will never fully appreciate, nor will I be able to fully describe, the experience of someone who did so within a culture that does not cater to people who look like them. In chapter five I will discuss that dilemma, along with some recommendations to mitigate that concern. I will also outline other issues with the work, and I will discuss implications of the findings. Finally, I'll discuss recommendations for faculty, professional leadership, and future scholars conducting similar work.

Chapter Five

Discussion

In this chapter I discuss the experiences of Black Nurse Anesthetists before and during their nurse anesthesia training utilizing a Critical Race Theory (CRT) lens. It should not be lost on the reader that these participants represent survivors. Each individual who spoke with me has successfully completed a nurse anesthesia educational program and is now a practicing nurse anesthetist. This brings up the question: what of those for whom the sabotage, the “othering”, and the microaggressions, combined with the rigors of nurse anesthesia education, were too much? How many talented prospective applicants and students were unable to overcome the barriers in their path? Someday, perhaps, I will be able to find a way to reach those individuals and allow them to share their stories. For now, though, we must work with the experiences of those who were able to overcome barriers and successfully complete their education.

I begin with an overview of the study. I discuss data collection and analysis. I outline the connections I see between the themes I uncovered during data analysis and the vast array of reading I did for this project, to include relevant professional literature as well as those cultural studies and critical race theory scholars from whose work I am still learning. I discuss my findings, and what I see as pertinent implications of those findings, and I lean heavily on CRT in my interpretation of the findings. I reflect on my role as researcher. I discuss my connection with the participants in this work, and I describe how I came to see them as fellow scholars on a similar journey to my own. I outline the many limitations of this work with an eye toward helping future scholars craft nursing scholarship with a cultural studies focus. I address recommendations to professional organizations at the state and national level for increasing

programmatic and professional diversity. I conclude with a discussion of further considerations and a summary of the study.

Overview of Study

The purpose of this study was to examine the experiences of nurse anesthetists who self-identified as Black or African American during the process of becoming a nurse anesthetist using interviews. The research questions were:

1. What is the educational experience of persons whose racial/ethnic background differs from the racial/ethnic background of the majority of nurse anesthetists? Specifically, what is the educational experience of Black applicants and students in nurse anesthesia educational programs?
2. What factors helped these individuals as they progressed through their program of study in nurse anesthesia?
3. What factors were perceived as barriers to the successful completion of a nurse anesthesia educational program?

The process of becoming a nurse anesthetist begins well before an application to a nurse anesthesia educational program is submitted, because nurse anesthesia students are required to obtain a minimum of one year of practice as a critical care nurse prior to matriculation into a program (AANA, 2017). Aspiring nurse anesthetists make a conscious choice to obtain high-acuity intensive care unit experience at some point during their nursing career. Thus, I included

the application and interview process in my examination of the pathway to nurse anesthesia, and some participants discussed the challenges they faced in acquiring that necessary experience.

In 2017, roughly three percent of nurse anesthetists are Black/African American (AANA, 2018)). That is the lowest percentage of any Advanced Practice Nursing specialty – Nurse Practitioners and Nurse Midwives are roughly eight percent Black/African American. When diversity is examined as an issue within the profession, it is often dismissed. The myth of meritocracy is alive and well in nurse anesthesia, and that observation is borne out by discussions at nurse anesthesia conferences and on nurse anesthesia discussion boards, as outlined in Chapter Two. The notion that there might be barriers to the successful completion of a nurse anesthesia educational program for people from different backgrounds is often dismissed as ludicrous. And yet, the numbers imply that barriers exist.

It seems that those of us who serve as members of admissions committees and as faculty are missing some key information, and that we might fill in the gaps in our knowledge by listening to people who have lived a different experience than our own. The purpose of this study, then, is to allow participants to tell their stories. To that end, I crafted brief, open-ended questions designed to uncover barriers and aids encountered by each individual as they navigated the nurse anesthesia educational system.

At the end of the interview, I gave participants free reign to discuss anything they wanted to discuss, related to the issue at hand or not. All participants opted to continue the discussion related to nurse anesthesia, with varied areas of focus. Some wanted to discuss methods for recruiting a diverse student pool, some wanted to discuss the weight of the trauma they still carried from their nurse anesthesia educational program, and some wanted to discuss working in the profession as a relative outsider due to their racial or ethnic background. Having allotted two

hours for each interview slot, I was able to remain available until each participant opted to end the conversation. There is value, I think, in having someone give weight to your experience. The participants shared their experiences freely for my benefit, I hope that I gave some benefit in return by being present and by listening.

Data Collection

When working with busy professionals, scheduling interviews is always a challenge. I wanted each participant to have ample time to discuss their experiences to the extent they wished, without rushing them. Interviews were scheduled for a two-hour period, but rarely took more than an hour, which allowed me to make notes after each interview period.

Recruitment of participants was initially slow, but I was contacted by a colleague who runs an innovative diversity program for aspiring nurse anesthetists to explain the nature of my work. She shared my call for participants with her network and my interview schedule rapidly filled after that. It should be noted that this particular colleague ignored my attempts to contact her for about a year regarding the subject of her dissertation. This was probably at least partly due to an incredibly busy schedule because she is a practicing clinician and the founder and director of a busy nonprofit organization, but also in part because initially I had no credibility. It seems that serving on the Diversity and Inclusion committee and writing and speaking about the need for diversity opened doors for me within the Black community.

Some potential participants were asked to participate in future research, because I had sufficient numbers for this study but also because I want to work with a diverse group of scholars moving forward. One participant in this work told me that if I were Black I would get more honest responses. I think that is probably an accurate assessment, but I feel as though this work had to be started in order to legitimize it. Having achieved some degree of professional respect

within the nurse anesthesia community for work unrelated to diversity gives credence to this work, and I may be able to foster the work of future scholars from diverse backgrounds.

I was contacted by several student nurse anesthetists, but I explained that they were in a vulnerable position as students and asked that they contact me after graduation if they were still interested in discussing their experiences. Each verbalized understanding and agreed to contact me in the future. It is my intent to conduct multiple iterations of this work, and I would like to involve scholars from diverse backgrounds to collaborate with me, as noted earlier.

Data Analysis

After the interviews were complete, I hired a transcriber to transcribe the content. I then entered the data into Nvivo and began the coding process. I initially coded the data into a set of codes and themes, and then coded the data again. Then I experienced what I can only describe as an acute attack of imposter syndrome following a rough patch personally and professionally, and I decided that perhaps I should return to a clinical job with set parameters and a defined workweek. I symbolically scrapped all of my data and started amassing a clinical case database. After coming to terms with my own insecurity, and recognizing that I can best bring about the changes I wish to see in the profession from an academic position, I reengaged my data. Fortunately, I had enabled an autosave feature in my Word documents, so I did not lose any information from the transcripts or from prior work. I entered the transcripts into Nvivo again, and re-coded the material.

It turns out that coding your data multiple times is a legitimate strategy (Creswell, 2007), and my seemingly nonproductive time was productive after all. My existential crisis served a purpose. The third coding was more intuitive, and I felt that I had a better grasp of how the data

fit into themes. After the third coding, I read the transcripts again, and made further adjustments to the themes and codes.

I realized upon the third reading that I had focused almost entirely on negative information, and it highlighted the importance of self-awareness on the part of the researcher when acting in what I came to regard as the research space. I have since defined the research space not just as a physical location but also as a mental one. Any space in which I am engaging my topic has become my research space. The research space consists of both the physical space I occupy and the chronological and cognitive space I allot for the work. I have always been very careful about my mindset and my positionality within my clinical space, because I sincerely believe that both affect the care I provide. It turns out that such caution with mindset and positionality is equally valid for me in my research space. This really should not be a surprise. Scholarly work has a less acute influence on population health than clinical work, but the influence is arguably more permanent.

This experience leads me to believe that I might be well-served in future work by giving the coded data and myself a few days to rest between coding sessions. My mindset affected my interpretation of the data, and did so despite my best intentions of approaching the material objectively. I think that the initial coding might be best viewed as a preliminary coding outline, and a second coding adds depth to the work because I found myself approaching the second iteration with some sense of the phenomenon in my head. The third coding might be the final coding, depending on the breadth and depth of the data. The key insight gained here was an understanding that the finished coded data may look somewhat different from the initial work, and that that is part of the process.

It is also true that social justice work is really hard. It is often painfully slow, two steps forward seem inevitably to be accompanied by three steps back, and it is largely a thankless endeavor. In fact, social justice work is often met with skepticism or with outright hostility. This process of formal social justice scholarship is teaching me the importance of maintaining perspective, and of engaging in a regimen of self-care. I often remind students that they cannot pour from an empty pitcher. By this I mean that they cannot provide high-quality patient care if they are completely drained when they enter the clinical arena. The same advice is applicable to scholarly work, particularly in the social justice realm. I am still learning the balancing act.

Themes and Connections

Data was grouped into the following broad categories: Resources, Exclusion, Hazing, Inclusion, and Significance. In the Resources category, the themes identified were: awareness, navigating the system, and funding. In the Exclusion category, the following themes were identified: segregation, I don't belong, proving. In the Hazing category, identified themes were: misidentification, mistreatment, coping strategies. In the Inclusion category, the themes included: representation, mentorship, outreach. In the Significance category, the key themes were: recognition and purpose.

Relationships between categories and themes are complex and nonlinear. I created a concept map in order to try to make sense of the data, and I decided that the linear relationships depicted in the map are accurate, but that many of the themes are also interconnected. Thus, my initial concept map evolved (see below). The first iteration (Figure 5.1) demonstrates how the themes fit the categories, while the second iteration (Figure 5.2) demonstrates connections between the themes. The more I considered the relationship between the themes and categories I uncovered, the more connections I seemed to see. I suspect I could develop another concept map

that would reveal more connections, but time is always a limiting factor and I think it is sufficient to recognize that none of this material is simple or neatly aligned. This is complex, messy stuff. Cleaning it up and repairing the damage caused by decades of racism and racial inequality within the profession is the work of several lifetimes.

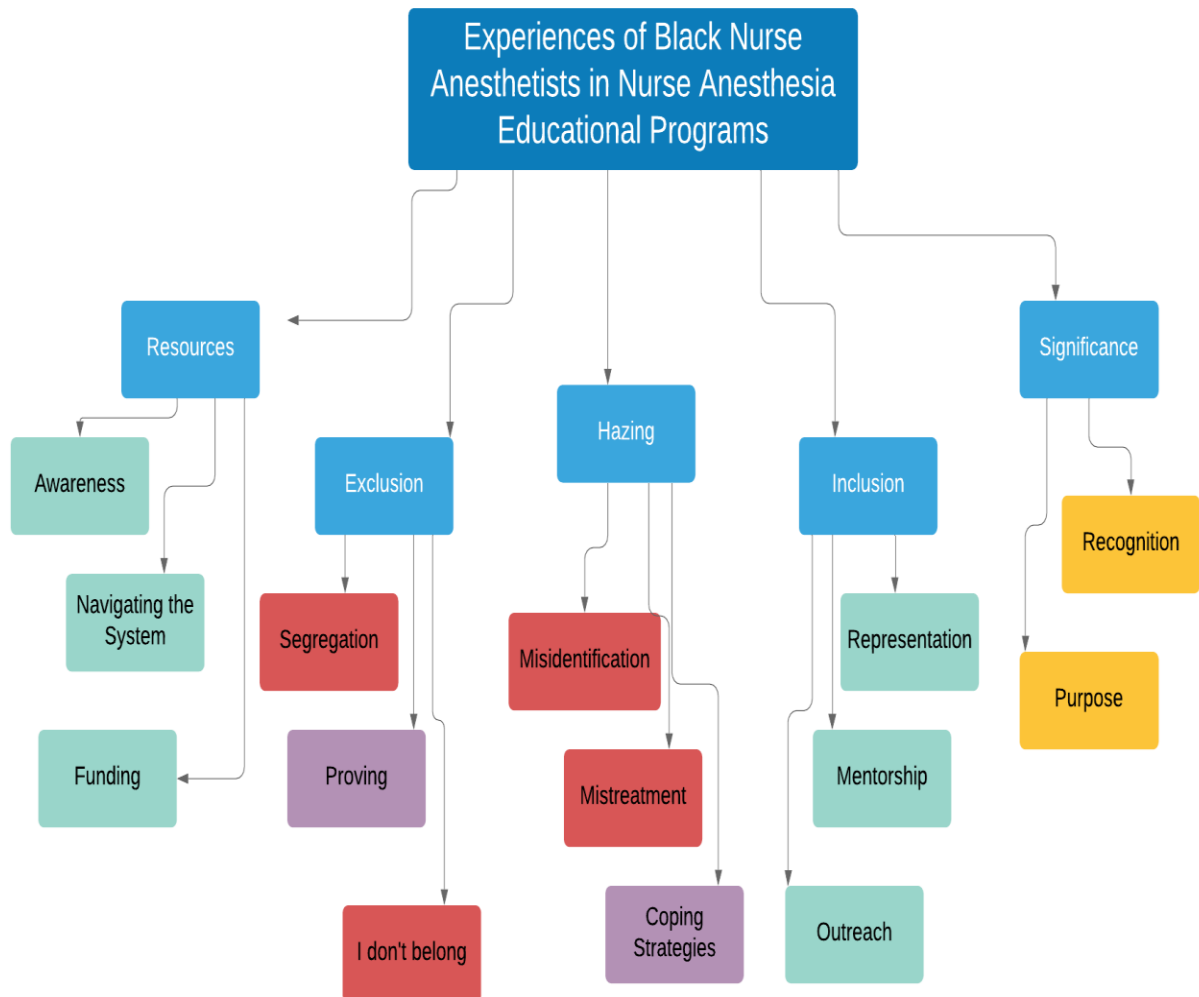


Figure 1 Thematic Concept Map

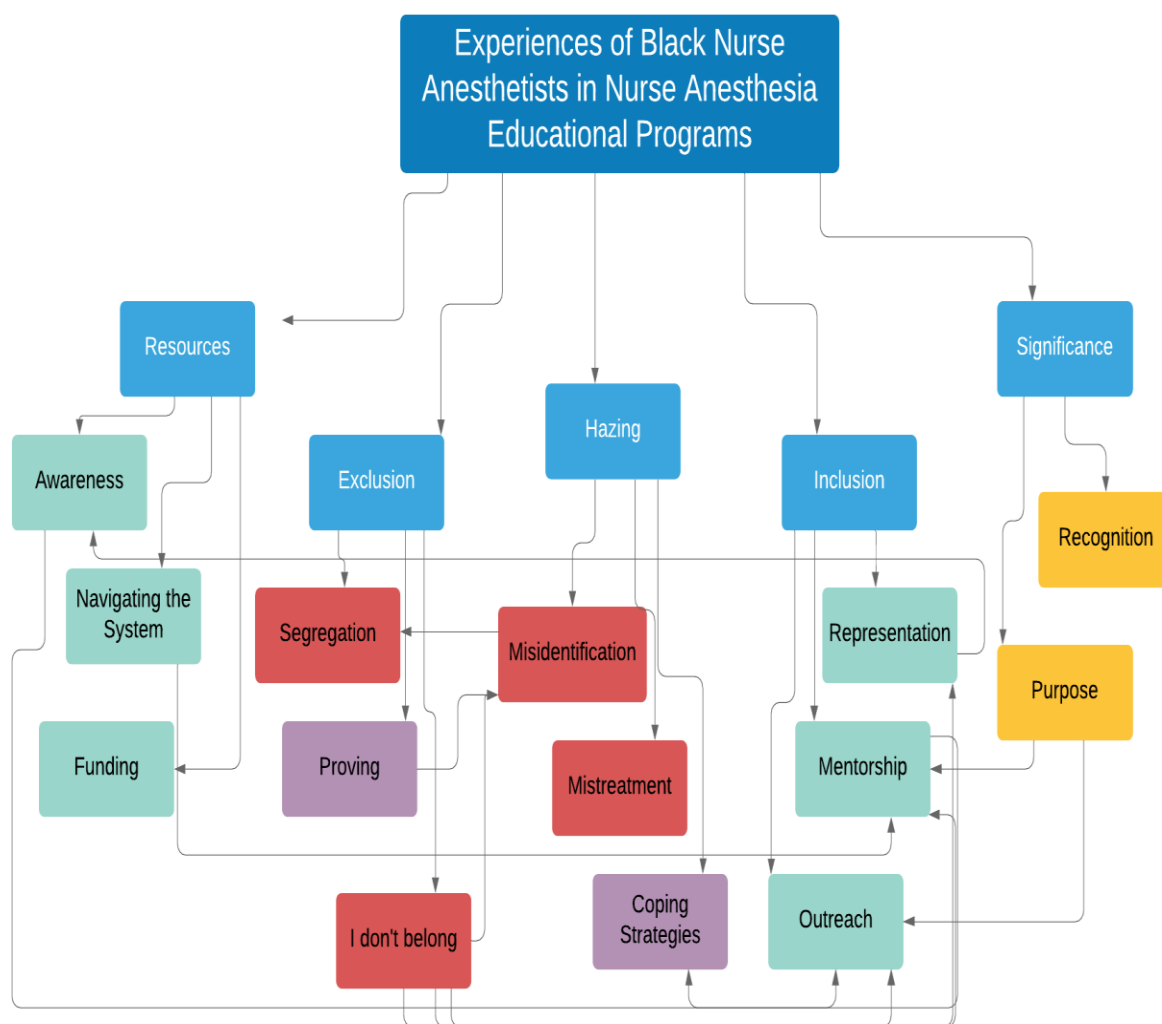


Figure 2 Thematic Concept Map with Connections

Findings

This work is unique in that it examines the experiences of persons from one racial/ethnic group prior to and during their nurse anesthesia educational experience. There is currently no literature addressing this period in any racial/ethnic group. In fact, there is very little information

about the nurse anesthesia student experience from any perspective. The work is further unique in that it utilizes Critical Race Theory (CRT) to analyze the experiences of nurse anesthesia students. CRT is becoming increasingly recognized as a valid method for analyzing race and racism in education (Evans and Delgado, 1982; Lopez, 2001; Parker and Stovall, 2004; Parker, 2015). The tenets of CRT that were utilized for this work include: experiential knowledge, the permanence of racism, interest convergence, whiteness as property, the critique of liberalism, and commitment to social justice (Crenshaw, 1998; Harris, 2001; Bell 1995).

Experiential knowledge is obtained via interviews with my research participants. Participants in this work reported a variety of barriers, some that are likely common to nurse anesthesia students across the board. Financial pressures are distressingly common because higher education is becoming more expensive and because it is difficult to work for income during a rigorous educational program. The Council on Accreditation of Nurse Anesthesia (2018) sets a limit on the number of hours students can dedicate to program-related work at 64 per week, but it is likely that many students spend additional time studying and preparing for cases without complaint. Additionally, students are required to complete call experiences, which involves evenings, nights, and/or weekends (COA, 2018). This requirement further limits a student's ability to pursue paid work. That this barrier exists is not likely a surprise to anyone affiliated with nurse anesthesia education. I am not certain, however, that the financial barrier is given adequate attention when looking to increase diversity. Financial barriers may be more difficult to overcome in persons from diverse backgrounds. Future work might make the case that financial barriers constitute an example of whiteness as property because of the history of wealth segregation in the United States (Hao, 2001), but I will leave that analysis to someone with greater financial acuity than I possess.

There may be barriers to matriculation of which the student is unaware, because the student is unaware of everything that takes place during the screening process. The screening process is that period where an admissions committee is determining which candidates to invite for an interview. Applications are scrutinized, essays and letters of reference are evaluated, and grade point averages are compared and ranked. Although this process is supposed to be anonymous, some students explicitly mention race/ethnicity in their application essays, and some student names suggest a particular heritage.

Students who are invited for interviews may also encounter barriers, visible and invisible, during and after the interview. Implicit bias on the part of application screeners and interviewers, for example, may make applicants from diverse backgrounds less likely to be accepted into nurse anesthesia programs, and this research would not uncover that barrier. However, a reliance on the “myth of meritocracy” (Kwate & Myer, 2010) might be more likely to make application screeners and interviewers impervious to their own biases. An earnest critique of liberalism is the key to toppling the comforting myth that the best candidates of any race will rise to the top.

Barriers reported by participants during their anesthesia educational program included microaggressions, hostility, “othering”, and even physical aggression. This sort of behavior directed at students is particularly egregious because the student is relatively defenseless. The student can file a complaint, but program and facility faculty must choose to intervene. If no intervention occurs, the student is more vulnerable than before the complaint was filed, because the behavior has been tacitly condoned by persons in positions of authority. The student must take that risk into consideration when contemplating filing a complaint, and it is very clear from my participants’ words that they know this. Most of my participants reported that they did not file a complaint about the hostile behavior they encountered.

Othering is the process of creating a space or separation between people who look and think like you or who share your culture and people who do not (DeCuir & Dixson, 2004). Participants reported experiencing othering in a variety of ways, including misidentification, disbelief in the participant's ability to manage the task at hand, and exclusion from group activities. Some participants report that othering has continued in their professional practice. Mistreatment and othering might all be attributed to the permanence of racism, and further connected to whiteness as property if one considers that these behaviors serve to further isolate and exclude folks on the margins.

Delgado and Stefancic (2000) describe the technique of counter-storytelling as a method of challenging the discourses of the majority and allowing the voices of marginalized groups to predominate. Is it fair to categorize Black/African American nurse anesthetists as marginalized? I think the combination of low numbers of Black/African American individuals within the profession, and the often shocking (from my perspective) anecdotes they related to me during this series of interviews makes the case for doing so. Open-ended interview questions allow participants to share their stories. In chapter four I center the voices of study participants and allow them to describe their experiences in a profession that is largely made up of white, middle-class individuals. Their words support the Critical Race Theory tenet that purports that racism is permanent (Bell, 1995).

The low numbers of Black/African American nurses who matriculate into and successfully complete nurse anesthesia educational programs may be an example of whiteness as property. Earlier in this work I discussed the benefits of a career in nurse anesthesia, including financial compensation and professional autonomy. Excluding people who are not white from

this career by erecting and maintaining barriers to success would serve to keep those benefits in the hands of white people.

The response to a discussion of diversity in nurse anesthesia invariably circles back to the myth of meritocracy (Kwate & Myer, 2010). If people are talented and capable, the thinking goes, they will rise above any circumstances. If someone fails to rise above their circumstances, clearly there is a lack of ability (merit) at play. A critique of liberalism (Hirald, 2010) mandates that we examine this flawed thinking and work toward dismantling the inequitable structures that tend to keep our academic and clinical spaces segregated.

I would be remiss if I did not admit that this work is a living example of interest convergence. First, there is an undeniable increasing push for diversity within the academy. Second, I am in pursuit of an advanced degree. It is true that I have always had a strong sense of fair play, but I will benefit from this work and that fact cannot be denied. My interests and the interests of my participants converge, in that we all want a more equitable and just future within the profession. The fact that a tenet of my theoretical framework serves to convict me does not mean that it can be ignored. In fact, I stand to benefit at this point more than my participants do, and they recognized that fact. And they willingly participated anyway.

It became apparent after speaking with all of my participants and coding their responses that none of them are asking for major programmatic changes. The recommendations given by most participants are simple. Program directors might consider making marketing materials inclusive. Make it clear that the program welcomes applicants from diverse backgrounds. One participant in this study suggested that simply including photographs of diverse individuals on the website would make a difference.

Consider mentoring applicants through the application process, and perhaps continue that mentorship during the educational program. Create an environment that is accepting of diversity. Consider earmarking some of your student funding to support candidates from diverse backgrounds. Program faculty and administrators should take student complaints seriously, and should take care not to place students back into a hostile environment at a clinical facility after they have disclosed microaggressions or hostility at that facility.

Implications

It seems clear that applicants from diverse backgrounds face barriers to the successful matriculation into and completion of a nurse anesthesia educational program. Whether those barriers are unique to individuals from a single racial or ethnic background is far from clear. It does seem, though, that these barriers have an effect on the diversity of the profession. It might be useful to identify barriers that prevent matriculation separately from barriers that affect program completion in future work.

I serve on the AANA Diversity and Inclusion Committee, and the committee has requested that the Council on Accreditation require programs to report the diversity of their applicant pool. To date, that request has been denied. It is difficult to pinpoint barriers that prevent matriculation without an accurate picture of what the application pool looks like. We cannot ascertain how many people from various disadvantaged subgroups are applying, and we cannot accurately identify acceptance rates by subgroup without this data. In other words, are application rates low among Black nurses, or are acceptance rates low? If we cannot pinpoint the problem, we cannot solve it. Furthermore, what is the racial/ethnic makeup of each program's attrition? Are Black nurses entering the profession but not completing their course of education?

We do not know, because we do not collect that data. Perhaps the publication of this work will help convince Council members that the request has merit.

It might also be useful to survey program faculty and admissions committee members for their perspective on barriers to matriculation into nurse educational programs faced by people of color. Are they aware of barriers that prospective applicants do not see? Since applicants do not see the files of other applicants, there are probably factors that affect admissions decisions that were not uncovered by this series of interviews. I considered this as part of my dissertation and discarded the idea due to time constraints, but will likely revisit it as a component of future scholarship.

It would also be useful to ask about faculty and admissions committee awareness of the role of implicit bias in decision-making. I suspect that many faculty and admissions committee members are unaware of their own implicit bias. Ultimately, a training module on implicit bias targeted to admissions committees and application screeners might result in at least the awareness of some of the barriers that people from different racial/ethnic backgrounds face. Perhaps this is a task that would be suited for the AANA Diversity and Inclusion committee moving forward.

Training for nurse anesthesia preceptors centered on implicit bias and appropriate precepting techniques might reduce the number of microaggressions and the level of hostility experienced by nurse anesthesia students. This might also reduce the number of incidents experienced by currently practicing nurse anesthetists, who report that such incidents still occur, because preceptors are practicing clinicians. Thus, the body of clinicians and the body of preceptors are the same. Making the clinical environment less hostile to students is a faculty responsibility. Does optimal learning occur when external stressors predominate? I think we all

know that it does not. Making an environment less hostile to current diverse clinicians also impacts professional diversity because people who experience hostility may leave a practice setting or leave the profession entirely.

Role of the Researcher

This study grew out of my observations of a lack of diversity initially within my own clinical anesthesia group in East Tennessee and of my observations of a lack of diversity at regional and national meetings. It was my cultural studies coursework, though, that highlighted that lack of diversity, allowing me to “see” what had been right under my nose for nearly a decade. I know that race and ethnicity does not determine intelligence, and I observed my colleagues from different racial and ethnic backgrounds working diligently in a variety of paraprofessional roles within the hospital. Work ethic is clearly not determined by racial and ethnic background, either. So why were there so few Black/African American nurse anesthetists? I realized that there was a story in the numbers, and my cultural studies readings were telling me that the right thing to do in this situation is to center the voices of people who are not normally at the center of the discussion.

In my mind, this is an issue of social justice, and thus it ties back into Critical Race Theory as methodology and to the tenet of commitment to social justice. This work reflects my commitment to social justice. I grew up in a family who moved from the Southern United States to Appalachia and back again in search of farming success, which my father never found. As an adult, I worked several minimum-wage jobs before taking a job as a nursing assistant. I subsequently obtained a series of certifications and degrees in nursing. With each degree my own socioeconomic status improved. By the time I successfully completed my nurse anesthesia

program, we were solidly upper middle class. I think that that same opportunity ought to be available to anyone with the willingness and ability to put forth the work needed.

I further see this as a social justice issue in terms of access to care. There is a significant shortage of nurses and advanced practice nurses in the United States (AACN, 2019). That includes nurse anesthetists (Rivera, 2018). We simply do not have enough qualified people opting into the nursing profession. If there are artificial impediments to entry and/or advancement, it behooves us to dismantle those impediments and facilitate the education and training of more care providers. How can we afford to exclude willing hearts and willing hands? We cannot continue to exclude entire groups of people who are willing and able to do the work of patient care. It is my sincere hope that this work serves to further the conversation about diversity and inclusion in nursing and nurse anesthesia.

Finally, although it is difficult to make a direct case between the racial and ethnic makeup of the healthcare workforce and the racial/ethnic health disparities that are common in the United States, I think it is worth mentioning that the Health Resources and Services Administration (2018) does exactly that. If there is a chance that increasing the diversity of the healthcare workforce could decrease health disparities in the United States, and if I have successfully made the case that increasing diversity advances social justice, how can we not try?

Limitations

This work has limitations that were shaped by issues related to research design and by issues related to the researcher. Design issues included the number of participants and participant recruitment techniques. Researcher issues included time constraints, access to participants, and my own preferences and biases.

It is often the case that qualitative work is limited in terms of generalizability (Creswell, 2007), and this qualitative study is no exception. First, the sample size is small. Although there was ultimately sufficient interest in participation to support the study, recruiting took more time than I envisioned. I placed an announcement on two professional message boards, but some of my participants heard about the study from other participants and reached out to me to request inclusion. Subjects, then, were those who tended to be more active either on a professional discussion board or within an existing diversity initiative. This may have affected the data because this group of participants may share traits that affected their experience in nurse anesthesia education.

Researcher-related issues affected the study, as well. Time constraints are a constant pressure that shape and direct the work. For instance, due to professional time constraints I scheduled interviews in the evenings, and I hired a transcriptionist to transcribe interviews to further alleviate time stress. I limited the scope and focus of the study to fit time constraints, and have planned to conduct multiple iterations of the study as opposed to one large piece of work. This may have affected my results and thus, my conclusions and recommendations. Participant access was further challenged because my participants are working nursing professionals and operating rooms tend to be open most of the time. Scheduling interviews was a constant struggle, and was certainly a factor in limiting the size of this work.

Researcher bias is an expected limitation of any qualitative study (Creswell, 2007). I addressed my background and my positionality in chapter one. I am a white woman in a privileged position in the educational setting of this study. I sit on a nurse anesthesia program admissions committee and I influence admissions decisions. I teach in a nurse anesthesia educational program and I supervise clinical experiences for nurse anesthesia students. I am

convinced that the rigor of a nurse anesthesia program is absolutely necessary for patient safety, given the role of the nurse anesthetist. It is important to recognize, though, that this stance may contribute to the lack of diversity because academic rigor generally requires a student's full attention. It is difficult to give your full attention to your course of education if you are experiencing a financial crisis, for example, or if people are treating you poorly based on an aspect of your person over which you have no control. Additionally, I may be equating Eurocentric cultural behavior with appropriate behavior for nurse anesthesia students. My own bias, then, may be problematic in terms of meeting my diversity-related goals.

The final limitation, as noted earlier, is generalizability. These results cannot be generalized because the number of participants is small and because of the qualitative design. Every individual's experience in nurse anesthesia education is unique. The intent of this work, though, was to center the voices of people who had experienced the nurse anesthesia educational system from the perspective of someone who is facing the challenge of an intense educational program while simultaneously balancing the "status problems" that Ogbu (2004) described. Even without generalizability, there is useful information in these stories as the profession works toward building a more diverse workforce.

One participant confirmed something I had suspected, noting that I would have more honest results if I shared the racial/ethnic background of my participants. I suspected that my ethnicity might be a barrier to open communication. I cannot change my race and ethnicity. I can simply acknowledge my race, my positionality, and my biases, and continue to encourage other researchers from diverse backgrounds to explore diversity-related work. I also believe that my handling of this work may serve to build trust for future iterations of the work. I wonder if subsequent interviews with the same participants would have different results if indeed I did

build an enhanced level of trust. The data might be significantly more rich if I had an established and trusting relationship with participants. It might be worth conducting a second set of interviews just to see what data emerges.

Recommendations for the Profession

Although qualitative work may be limited in generalizability (Creswell, 2007), this work is still useful in terms of considering strategies to increase diversity in nurse anesthesia educational programs. It is useful to consider the categories and themes used in the data analysis as I outline recommendations. In Table 5.1, the categories and themes are outlined.

Table 2: Categories and Themes, Revisited

Resources	Exclusion	Hazing	Inclusion	Significance
Awareness	Segregation	Misidentification	Representation	Recognition
Navigating the system	I don't belong	Mistreatment	Mentorship	Purpose
Funding	Proving	Coping strategies	Outreach	

Professional organizations, specifically the AANA and state nurse anesthesia organizations, can influence resources available to nurse anesthesia applicants from diverse backgrounds by raising awareness of the profession as a viable option for people from all walks

of life, and by making sure that prospective applicants understand the steps that need to be taken to ensure successful matriculation into and completion of nurse anesthesia educational programs. Funding is an issue for students from all backgrounds. Funding issues can be addressed by earmarking scholarship funds for diverse candidates. Alternately, with the current shortage of anesthesia providers, it might be worth exploring an organizational partnership with health facilities and/or states to provide stipends to students from diverse backgrounds. Health facilities would benefit from a commitment to work a set amount of time within the facility and students would benefit from funding during school and immediate employment upon graduation.

Exclusion can be addressed in a variety of ways. First, educational offerings for the membership as a whole on the problems associated with a segregated healthcare workforce might empower practicing nurse anesthetists to act to end segregation in their practices by inviting individuals from diverse backgrounds to apply for employment. A nationwide advertising campaign featuring nurse anesthetists from various racial and ethnic backgrounds utilizing a “You Belong at the Table” theme might address both segregation and issues of belonging. The profession could further highlight practicing nurse anesthetists from different backgrounds along with their accomplishments, thus demonstrating that persons from various backgrounds do belong and can be successful.

Hazing should never be accepted. Nurse anesthetists who participate in hazing behaviors are engaged in professional misconduct and should have to answer to our licensing body. There should be a zero-tolerance policy for this sort of misbehavior. An escalating series of consequences for hazing behaviors might be instituted, starting with a warning, progressing to fines and professional censure, and ultimately resulting in a suspension of licensure if the behavior is not corrected. This behavior could also be addressed via the human resources

department of the individual's employer or practice site, as well as via the associated educational institution when students are involved. Students and practicing clinicians should not have to develop coping strategies to deal with hazing behaviors, those behaviors should be eliminated.

Training modules for admissions committees, faculty, and preceptors was discussed in the implication section of this chapter. I recommend the creation of training modules for the professional organization and I further recommend that these modules be offered to organization members without charge and with associated continuing education credit in order to incentivize completion. The modules could be developed at little cost if they were taken on by doctoral students in need of scholarly projects.

The nurse anesthesia community as a whole can tackle inclusion. Welcoming clinicians from different backgrounds is critical to ensure a diverse professional body. Individual nurse anesthetists can reach out to aspiring nurse anesthesia applicants from different backgrounds and consider serving as mentors. Many nurse anesthesia organizations have formal mentorship programs, but it is not clear how many of these programs have diversity initiatives built into them. If an organizational program does not include information on people from diverse backgrounds within the mentorship program, consider amending it. Representation matters, as well. Advertising materials for nurse anesthesia educational programs and professional organizations need to include a variety of individuals in their advertising materials and on their webpages.

Recommendations for Future Work

This is the first study, to my knowledge, that examines the experiences of participants in nurse anesthesia educational programs. Since so little information is available about the

experiences of nurse anesthesia students, my first recommendation is that this work continue. There are many more stories to be told, and there is value in listening, and in learning from one another. I intend to continue this work with a second series of interviews beginning in Summer, 2020. I also recommend recruiting scholars from various racial and ethnic backgrounds to participate in the work. To that end, I would like to establish a research group to assist novice researchers in launching their programs of inquiry.

Interviews or surveys of students from all racial/ethnic backgrounds about barriers, with answers separated by demographic data might give a more clear picture of how each group differs in its experience of the same phenomenon. At present, there is no data available for comparison when discussing barriers and assists for applicants and students. It is difficult to make the case that these barriers and adjuncts are exclusive to any one group without comparative data.

Another recommendation I have is to consider other demographic factors when considering diversity. Interviews with people from other racial/ethnic backgrounds who are underrepresented within the profession is certainly warranted. Persons from various socioeconomic backgrounds and various sexual orientations may also be underrepresented within the profession. If inclusion matters, and I think it does, we need to look at inclusion holistically.

Finally, I recommend that some effort be made to reach out to prospective applicants and students who did not successfully complete a nurse anesthesia educational program. There are a lot of factors that may influence a student's success or failure, but it might be useful to examine the barriers faced by students within this group as compared to the barriers reported by persons who were successful. Issues may arise that did not come out in interviews with individuals that have successfully completed an educational program.

Conclusion

The purpose of the study was to examine barriers and assists to successful Black/African American nurse anesthesia students. To achieve that end, I interviewed twelve practicing nurse anesthetists from across the United States. I took pains throughout this work to conceal participant identities, including masking gender, ensuring that participants could not be connected to anecdotes, and concealing geographic location. I did this because I do not want any backlash affecting individuals who were willing to share their experiences.

This study supports the conclusion that we, as a profession, can do more to increase diversity within the profession. Most of the barriers raised in this research can be addressed by individuals, nurse anesthesia programs, and nurse anesthesia professional organizations. It is clear from the literature review that most initiatives designed to improve diversity have a positive effect. Armed with that knowledge, how can we fail to take action?

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APPENDICES

APPENDIX 1

CONSENT TO PARTICIPATE IN A STUDY Identifying Barriers to Diversity in Nurse Anesthesia

INTRODUCTION

You are invited to participate in this research study that investigates diversity in nurse anesthesia. The purpose of this study is to identify the barriers that may exist to entry into the profession for nurses from diverse backgrounds.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

If you decide to participate in this study, you will be asked to complete an interview via Skype or Zoom. The interview will last about an hour.

RISKS

There is minimal risk associated with this study that may include a possible breach of confidentiality. However, the researcher will take all necessary precautions to minimize this risk. Some questions may bring up unpleasant memories from your past. You may refuse to answer any and all questions posed by the interviewer, and you may stop the interview at any time.

BENEFITS

There are no anticipated direct benefits to individuals resulting from your participation in this research. However, there are a number of general benefits of the study may help provide more information on the barriers encountered by persons who belong to groups that are currently underrepresented in the profession. It is hoped that this information will aid in devising strategies that can be utilized by faculty and by the professional organization to improve the diversity of the profession.

CONFIDENTIALITY

The information in the study records will be kept confidential. Data will be stored securely on a password secured laptop and will be made available only to persons conducting the study unless participants specifically give permission in writing to do otherwise. No reference will be made in oral or written reports which could link participants to the study. Your research information will not be used or shared with other researchers for future research, even if identifiers are removed.

CONTACT INFORMATION

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Dr. Terrica Durbin, at tpreast@utk.edu and (865) 306-5688. If you have questions about your rights as a participant, you may contact the University of Tennessee IRB Compliance Officer at utkirb@utk.edu or (865) 974-7697.

PARTICIPATION

Participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without

loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be kept strictly confidential.

CONSENT

I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's Name (printed) _____

Participant's Signature _____ Date _____

APPENDIX 2



THE UNIVERSITY OF
TENNESSEE
KNOXVILLE

May 02, 2019

Terri Durbin
UTK - College of Nursing - College of Nursing

Re: UTK IRB-19-05149-XP

Study Title: Identifying Barriers to Diversity in Nurse Anesthesia Education

Dear Terri Durbin:

The Human Research Protections Program (HRPP) reviewed your application for the above referenced project and determined that your application is eligible for **exempt** review under 45 CFR 46.101. Category 2: Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior unless, the information is obtained in an identifiable manner and any disclosure of the subjects responses outside of research could reasonably place the subject at risk.

Your application has been determined to comply with proper consideration for the rights and welfare of human subjects and the regulatory requirements for the protection of human subjects. This letter constitutes full approval of your application (Version 1.2) as submitted, including:

Durbin informed consent - Version 1.1

Durbin recruitment notice (2) - Version 1.2

Durbin Interview Questions (1) - Version 1.1

The above listed documents have been dated and stamped IRB approved 5/2/2019.

In the event that volunteers are to be recruited using solicitation materials, such as brochures, posters, web-based advertisements, etc., these materials must receive prior approval of the IRB.

Any alterations (revisions) in the protocol must be promptly submitted to and approved by the UTK Institutional Review Board prior to implementation of these revisions. You have individual responsibility for reporting to the Board in the event of unanticipated or serious adverse events and subject deaths.

Institutional Review Board | Office of Research & Engagement
1534 White Avenue Knoxville, TN 37996-1529
865-974-7697 865-974-7400 fax irb.utk.edu

BIG ORANGE. BIG IDEAS.

Sincerely,

Colleen P. Gilrane

Colleen P. Gilrane, Ph.D.
Chair

Institutional Review Board | Office of Research & Engagement
1534 White Avenue Knoxville, TN 37996-1529
865-974-7697 865-974-7400 fax irb.utk.edu

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APPENDIX 3

INTERVIEW QUESTIONS

1. Please describe your experience in nurse anesthesia education.
2. Please describe the admissions process.
3. Please describe any barriers you encountered during the admissions process.
4. Please describe anything or anyone that assisted you during that process
5. Please describe your anesthesia education.
6. Please describe any barriers you encountered during your course of education.
7. Please describe anything or anyone that assisted you during the course of your education.
8. Do you have any recommendations for faculty members and admissions committees that might increase programmatic diversity?
9. Is there anything else you would like to discuss before we close this session?

Figures and Tables

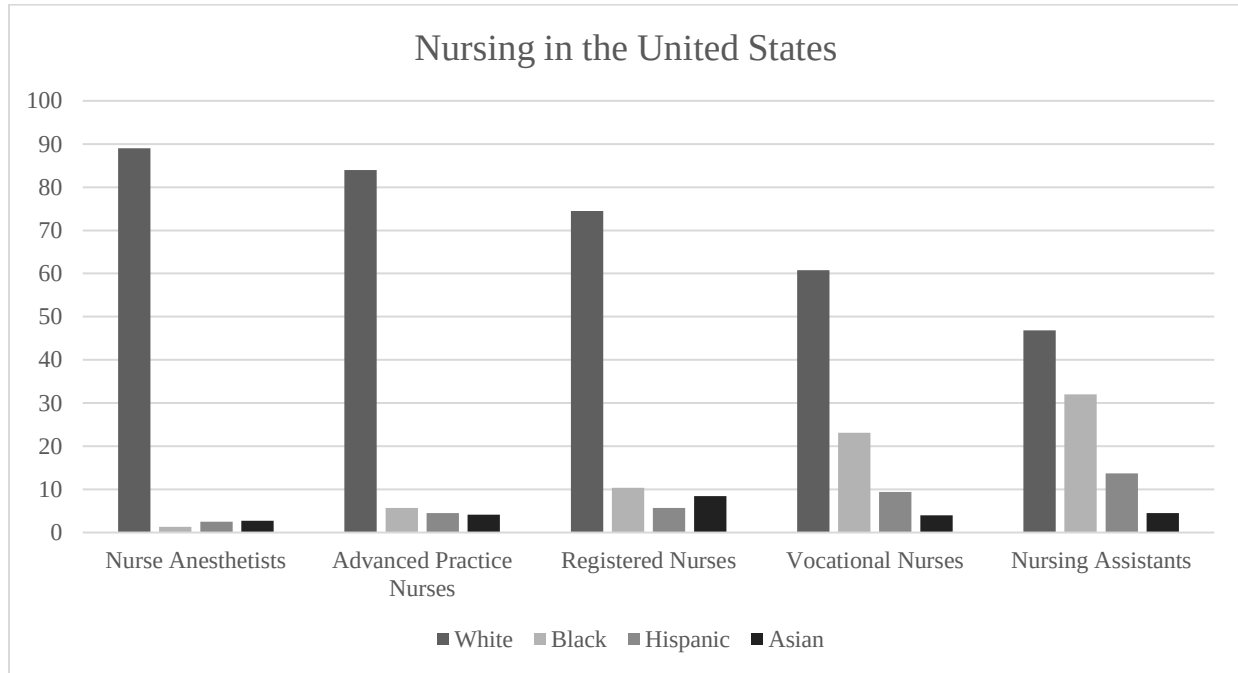


Figure 3. Racial/Ethnic Makeup of the Nursing Profession

Data courtesy of the American Association of Nurse Anesthetists (2019) and the Health Resource Services Center (2016)

Table 3: Nurse Anesthesia Literature Table

Authors	Design/Met hodology	Frame work	Sample	Results	Limitations	Discussion
Kilburn, F., Hill, L., Porter, M. D., & Pell, C. (2019).	Authors tested various recruitment strategies over three 12-month periods	None,	407 applicants; 97 admitted	2015-17 14.4% POC 2016-18 24.5 POC 2018-20 27% POC	Generalizability – one graduate program	UTC used various recruitment strategies
Gibbs DM, & Waugaman WR.	Examination of demographics of Barry University	None	186 students admitted over 5 years	16% of students were POC	Really not a study at all; descriptive	Increasing racial/ethnic diversity might be lowering admissions standards?
Worth P.	None, this is a historical report	N/A	N/A	Discussion of Black nursing leaders	Not a study, useful in terms of cultural context	Highlighting the stories of Black nursing pioneers.
Gould, W.	Mixed methods study. Surveys and focus groups. group interviews for qualitative piece of study.	Transcultural nursing	Quantitative – n = 151 Minoritized CRNAs (n=31); Minoritized CRNA students & ICU nurses (n=94) and PDs (n=14). Qualitative piece n=14.	Varied – several focus groups and a survey	Generalizability – refers to one specific type of diversity interventions. Author-identified limitations include potential bias.	Informative description of demographics discussed in programs to any extent).

VITA

Terrica Durbin earned a Bachelor of Science in Nursing at Lewis-Clark State College in Idaho, followed by several years in the military as a critical care nurse. She earned a Master of Science in Nursing with a Nurse Anesthesia focus from the University of Tennessee, Knoxville, and a Doctor of Nursing Practice in Acute Care Nursing from the University of Tennessee Health Science Center. Terrica serves as faculty in the College of Nursing at the University of Tennessee, Knoxville. She is passionate about reducing health disparities and is active in the Rural Health Association of Tennessee, the Tennessee Association of Nurse Anesthetists and the American Association of Nurse Anesthetists. Her research interests include diversity in education and in the healthcare workforce, cultural studies, and adult learning.