Against the Grain: Examining the Experiences of White Healthcare Providers Involved in Racial Justice Work

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Dedication

To the great Liberator, thank you. Without you, none of this would have been possible!

My work is dedicated to those who poured into my life and have since become my ancestors. Thank you for your unwavering support and belief in me. Daddy, I did it. Neake, I finally started swimming in the deep end. I wish that you could have been here to see it. Mack and Shirley, you were right. Finally, I know both my grandmas are enjoying this moment. Tera, Malinda, Howard, Cornelius, thanks!

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To sing about freedom and to pray for its coming is not enough. Freedom must be actualized in history by oppressed peoples who accept the intellectual challenge to analyze the world for the purpose of changing it.

--James H. Cone

Finally, this work is for the people who lost their lives in the fight for racial justice and those who struggle every day against oppression for racial and social justice. May we achieve health equity and realize that our fate is inextricably tied to each other.

May the spirit and the strength of the great Liberator guide my words and deeds, and when all is said and done, may they be acceptable in the Liberator's sight (ESV, n.d.),

Abstract

During the COVID-19 pandemic of 2020, racialized people in the United States faced devastating health outcomes. However, the disastrous fissures in the healthcare system predated the 2020 COVID-19 healthcare crisis. Prior research demonstrates that Black people outpace all other groups for inequitable health outcomes, and Black providers are under-represented in healthcare. While there has been some research around interventions, much of the research chronicles the inequities and implicates structural and interpersonal white supremacy and racism in healthcare. There is a gap in the literature around white healthcare providers involved in racial justice efforts. This qualitative Interpretative Phenomenological Analysis situates health inequities for Black people within the historical and contemporary context of white supremacy and racism. It examines the experiences of 22 white healthcare providers involved in racial justice work. Findings demonstrate three key themes: The omnipresence of racism and white supremacy in healthcare; anti-racism (racial justice worker) identity development; and reconciling racism and white supremacy in healthcare. The findings have implications for healthcare leadership, education, research, policy, and practice. The findings also have critical relevance for those invested in racial justice work in healthcare.

Key words: race, racism, white supremacy, anti-racism, racial justice work, white healthcare providers, Critical Race Theory (CRT), Critical Whiteness Studies (CWS), health equity

General Summary

Health inequities are not new. Researchers have studied the impact of health inequities on the lives of Black and other people of color for years. While there has been some research to examine interventions to improve health equity, the COVID-19 pandemic in 2020 exposed the impact of racism on healthcare in the United States. The impetus to find strategies to mitigate the effects of racism and white supremacy in healthcare has never been more urgent. There is a gap in the literature examining white healthcare providers involved in racial justice work. The current study examines the experiences of white healthcare providers involved in racial justice work. White healthcare providers who identified as social workers, doctors, nurses, or health scientists and engaged in racial justice work were asked to share their experiences with racial justice work. The findings described the white healthcare providers' perceptions of the omnipresence of racism and white supremacy. They also described white healthcare providers' experiences with their anti-racism (racial justice worker) identity development. Finally, the findings point to how white healthcare providers reconcile racism and white supremacy in healthcare. The findings are relevant across healthcare and provide tools for administrators, healthcare providers, and health equity advocates to resist and disrupt racism and white supremacy in healthcare.

Chapter One: Introduction to the Problem and Research Questions

"Each generation must out of relative obscurity discover its mission, fulfill it, or betray it (Fanon, 1963, p. 206)." As in Fanon's time, racial injustice has impacted the lives and well-being of Black, Indigenous, and other people of color for generations, and yet, depending on your racial identity and social location's proximity to whiteness, the phenomenon seems to be relatively obscure (Nnawulezi et al., 2020). Research demonstrates that racial inequities in the United States are reified through a system of white supremacy and racism, which is undergirded by laws, institutional practices, and structural and personal interactions (Bonilla-Silva, 2018; Williams et al., 2019). A 2017 multi-disciplinary national survey of Black people found that Black people's personal experiences of discrimination in the United States of America (U.S.) across social systems are consequential and wide-ranging, with approximately 50% pointing to the discrimination in institutionalized systems as a significant problem (NPR, Robert Wood Johnson Foundation [RWJF] & Harvard School of Public Health, 2017). In a longitudinal study, a similar investigation of Black respondent's perceptions of racism compared several time points (Hamel et al., 2020). Findings indicated that of the Black men surveyed, 65% said it was "a bad time to be a Black man in America in 2020 compared to 28% with that sentiment in 2006, and 58% of the Black women surveyed said "it was a bad time to be a Black woman in America" compared to 15% in 2011. Fifty-eight percent of the Black people in this study reported they had "been treated unfairly because of their race in the past 12 months while shopping, working, interacting with police, or getting health care," and 79% reported that "systemic or structural racism is a major obstacle to Black people achieving equal outcomes to white people" (Hamel et al., 2020, p. 1). In the United States, the impact of the enduring legacy of white supremacy and racism results in inequitable treatment and disparate outcomes for Black and Brown (racialized)

people in education, health, justice, and wealth (Williams et al., 2019). This dissertation and body of research seek to expose the impact of health inequities for racialized people and explore an explicit path for racial justice work in healthcare.

Indeed, the social and structural determinants of health create impediments to attaining well-being across systems for marginalized communities; this often disproportionately results in adverse outcomes for Black people and other people of color (Towe et al., 2021). For instance, Hamel et al.'s (2020) study found that in 2020, 70% of Black people said that "the health care system often treats people unfairly based on their race or ethnic background," compared to 56% in 1999. Sixty-five percent of Black people said, "it is difficult to find a doctor who shares their background and experience," and 20% said that in the past 12 months, they had been "treated unfairly based on their race while getting healthcare for themselves" (p.1). The continued disproportionate impact of racism and white supremacy on the health of people of color cannot be understated, dismissed, or ignored, and practice, policy, and research must begin to interrogate and problematize this structural entrenchment of racism and white supremacy across social systems, but particularly in healthcare.

In 1946, The World Health Organization (WHO, 1946) describes the human quest for health and well-being as the following:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health (p. 6).

While the WHO (1946) describes the universality of a desire for health and well-being, the research indicates that for most racialized Black and Brown people, reaching their maximum potential well-being continues to be out of reach (Hamel et al., 2020; NPR, Robert Wood Johnson Foundation [RWJF] & Harvard School of Public Health, 2017). Activists and social scientists have highlighted the prevalence and striking significance of health inequities among Black and other people of color for years (Bailey et al., 2021; Du Bois, 1906; King, 1966; Towe et al., 2021; Washington, 2006). King's 1966 speech to the Medical Committee for Human Rights is still salient almost 60 years later. King (1966) stressed, "Of all the forms of inequality, injustice in health is the most shocking and inhumane (para., 1)."

The inhumanity of the injustice in health was put on full display during 2020-2022 as the United States of America (U.S.), along with the rest of the world, experienced the onslaught of COVID-19's high rate of transmission, infection, and fatality (Chen & Kriger, 2020). While the virus impacted everyone, the public quickly learned that certain populations faced the harshest impact (Andrasfay & Goldman, 2021; Shostak et al., 2021). The COVID-19 global pandemic revealed glaring racialized health inequities which were punctuated by 2020's global racial injustice protests denouncing murders of Black people by police officers, and coloniality, racism, and white supremacy around the world (Haynes, 2020). Meanwhile, under-resourced countries were reeling from the lack of access and inequity in the pricing and distribution of COVID-19 vaccines (Echavarri, 2021). The global interconnectedness revealed a trifecta resulting from white supremacy and racism: the underlying prevalence of racial injustice across systems, health inequities for Black and other people of color, and the glaring inadequacy of past and current approaches (Egede & Walker, 2020).

Specifically, health inequities exacerbated by COVID-19 point to the interconnectedness of poor health access, outcomes, and structural racism (Yancy, 2020). For most racialized people, the experience of having poor health outcomes and disproportionate suffering predates COVID-19 (Bailey et al., 2020; Feagin & Bennefield, 2014; Williams et al., 2019). The disparate results of the death and transmission rate among Black and other people of color during the height of COVID-19 were not created in an ahistorical vacuum and must be put into the context of the calls for racial justice in healthcare (Bailey et al., 2020: King, 1966; Jones, 2002; Murray-Lichtman et al., 2022a). As the COVID-19 crisis abates, the suffering of racialized people remains exacerbated and demands the attention of racial justice advocates (Woolf et al., 2021; Yancy, 2020).

The outcomes of a crisis like COVID-19 were highly foreseeable as they were predicated on systemic issues like ongoing underlying inequities perpetuated by racism and white supremacy that had been pointed out by scholars, activists, and scientists for over 100 years (Bailey et al., 2021; Du Bois, 1906/2003; Smedley et al., 2003; Washington, 2006). The disproportionate impact of COVID-19 with repercussions for all humanity across the global community removed any obscurity, revealing the health inequities faced by racialized Black, Indigenous, and People of Color (BIPOC) as one of the most significant racial injustice issues of our lifetime. Therefore, as with Fanon's (1963) fight against racial injustice, for this generation, the mission to decrease racialized health inequities is clear and must be fulfilled. Serious efforts to reduce health inequities must include strategies geared to address systemic racism and white supremacy within healthcare (Feagin & Bennefield, 2014; Jones, 2002; Washington, 2006). While 2020-2022 unveiled systemic injustices for the world to see, white supremacy and

structural racism will not be dismantled without research and policies that are translatable into anti-racism actions and interventions that derail systems of oppression.

The urgency to tackle racial injustice and health inequities demands radical actions that will upend business as usual (Egede & Walker, 2020). Researchers, policymakers, and practitioners cannot afford to revert to "epistemologies of ignorance," producing reports of health statistics and prevalence rates that individualize racial health inequities, enact colorblind policies for healthcare, or provide healthcare interventions that ignore the systemic impact of racism and white supremacy (Bowleg et al., 2017, p. 578). Research that overturns the status quo of "blaming the victim" and sheds light on the structural racism that creates, shapes, and maintains health and other systemic inequities is long overdue (Kirby & McKenna, 2004). For too long, research on health inequity has focused on the perceived deficits of racialized groups (Feagin & Benefield, 2014; James & Jordan, 2018; Nieblas-Bedolla et al., 2020). Strega and Brown (2015) suggest, "it is only when we reverse the gaze and investigate and problematize…the behaviors, discourses, and perceptions of the dominant—that we create possibilities for change that are transformative rather than incremental (p.6)."

This type of research does not fit neatly into Western epistemological standards yet despite years of "objectively" measuring the impact of white supremacy on the lives of Black people and years of theorizing about that impact, health inequities still claim more Black lives than any other group (Bailey et al., 2021). Hence, my research aims to turn the gaze on white people—mainly white healthcare providers to understand how they see racism and white supremacy and experience racial justice work (Razack, 1998). This research, using the stories of white anti-racist healthcare providers, allows insight into how the system of whiteness pays lip service to anti-racism in healthcare, enabling the system to preserve white supremacy (Feagin &

Bennefield, 2014). White people in healthcare must work to undo the harm that white supremacy causes (Cooper & Roter, 2003).

White healthcare leaders who are knowledgeable about the role of white supremacy and racism in health inequities must be willing to transgress boundaries and insist on change within healthcare and across social systems (Stefaniak et al., 2020; Towe et al., 2021). The U.S. has a disheartening history of racial justice gains and subsequent losses of racial justice progress along a slippery slope that relies on epistemic ignorance (Anderson, 2016; Bonilla-Silva, 2018; Bowleg et al., 2017; Peller, 2016). Much of the extant literature reports health outcomes that demonstrate inequities (Bailey et al., 2021); the health inequities and the devastation to racialized communities from COVID-19 must propel research that moves beyond *just* documenting inequity (Woolf et al., 2021; Yancy, 2020). There is a dearth of literature about white leaders in healthcare who recognize the problem and want to take anti-racism action (Bussey, 2021; Nnawulezi et al., 2020). Specifically, the experiences of white healthcare providers involved in racial justice work have been understudied.

This study addresses a gap in the literature by examining the experiences of self-identified white healthcare providers (doctors, nurses, social workers, and health-related scientists) involved in racial justice work. Borrowing from the tenets of Critical Race Theory and Critical Whiteness Studies, this study of white people involved in racial justice work enacts epistemic disobedience (Mignolo, 2009) and speaks back to power (hooks, 1989), seeking transformation by disrupting the status quo of white supremacy and racism in healthcare. Reversing the "gaze" provides the opportunity to critically approach health equity research through the realm of white healthcare providers involved in racial justice work (Carroll, 2004; Kirby & McKenna, 2004).

The research also employs strategic essentialism (Spivak, 1988) with Black people as an explicit entry point (Adjei, 2013) into the discussion as Black people experience the worst outcomes from health inequities (Phelan & Link, 2015). Spivak (1988) coined the term strategic essentialism to intentionally identify the consequences meted out or privileges awarded to specific groups of people based on the characteristics that the group shares (e.g., Black people and anti-Black racism or religion and Islamophobia) despite unique attributes or intersectional identities of individuals within the group. Invoking Spivak's (1988) strategic essentialism for this research allows it to speak with and on behalf of other Black people regarding the urgency of this moment for racial justice work (Alcoff, 1991; Baldwin, 1985; Du Bois, 1899/2013; Carlton-LaNey, 1999; NPR et al., 2017; Yancy, 2017).

Contextualizing Counter-Narratives and white Racial Justice Workers

In anti-racism research, context is *critical* as words are often co-opted and colonized (Bilge, 2013; Barthold, 2023), and academic voyeurism summarily weaponizes and dismisses specific knowledge (Murray-Lichtman & Elkassem, 2021). For this anti-racism research, criticality employs back-talk, a strategy to transform and transgress borders (hooks, 1989, 1994; Yancy, 2021). Despite political exhaustion, criticality must amplify resistance in the pursuit of racial justice (Emejulu & Bassel, 2020; Yancy, 2021), lest criticality becomes yet another tool of the master's house (Lorde, 1984) wielded either "consciously or unconsciously, to maintain and sustain Eurocentric academic supremacy (De La Torre, 2018, para. 5)."

The power of words to define and determine the sociopolitical realities of certain bodies cannot be understated (Said, 1997). Counter-narratives are birthed in struggle and have been an *ongoing* means to subvert and disrupt boundaries of racism and white supremacy (Combahee et al., 2014; Crenshaw et al., 1995; Delgado, 1989). As such, counter-narratives are vehicles to

interrogate, problematize, and trouble the ways race, racism, and white supremacy have shown up to frame social discourse, scaffold institutionalized oppression, and entrench white supremacy. Given the history of the struggle for racial justice in the U.S., complete with rollbacks of racial justice gains (Anderson, 2016; Bell, 1985; Crenshaw et al., 2021a; Crenshaw et al., 2021b; Du Bois, 1935) and the co-opting, colonization, and hijacking of racial justice terms and processes without the centering of race, racialization, and racism, (Bilge, 2013; Barthold, 2023), it is essential to contextualize the use of the terms *counter-narrative* or *counter-story.* In this instance, counter-narratives (narratives that disrupt white supremacist logic and narratives) bring to bear the work or *counter-actions* (actions against racism and white supremacy) of white people who fight to subvert and disrupt racism and white supremacy. White supremacy and racism find their perpetuity in the oppression and subjugation of "Othered" voices and bodies. The permanency of racism against the Black body (Bell, 1987, 1992/2018; Du Bois, 1920) coincides with the historical and systemic alienation of those bodies that join the sociopolitical struggle of the Black body.

The white people who actively participate in disrupting, opposing, and subverting white supremacy (by word *and* deed) in the struggle for racial justice, as Du Bois (2007) says, may come close to understanding the spatiality of Blackness and what systemic racism and white supremacy do to the those who embody Blackness. This research pulls in those bodies participating in counter-actions and voices that produce counter-narratives or counter-stories. Counter-narrative holders are oppositionists and a part of outgroups, those who stand in the way of and dislodge others from the dominant narrative (Delgado, 1989; Ladson-Billings, 2013). In this way, "the primary point here is that the chronicle or counter-story is about racial justice principles, not personal affront (Ladson-Billings, 2013, p.43)." As with other white people who

joined the historical struggle for racial justice (Crenshaw et al., 1995), the white healthcare providers in this research embody a racial consciousness of resistance to white supremacy, making them part of the outgroup from the dominant consciousness and as such their stories for racial justice become counter-stories of subversion and disruption (Delgado, 1989). Resistors of white supremacy must be part of the struggle to voice counter-narratives to the onslaught of white supremacy that functions to keep white supremacist logics and health inequities in place.

Research Questions

The implications of envisioning healthcare and racial justice work through the counter-narratives of white healthcare providers involved in racial justice work are critical to making changes in healthcare inequities. This research is essential to healthcare, specifically social work, whose ethics should inform anti-racism action. The qualitative research employs an Interpretative Phenomenological Analysis research design. The phenomenological research questions are: 1) What are the experiences of white healthcare providers involved in racial justice work in healthcare? This question seeks to unpack the activities, opportunities, or things white healthcare providers do on behalf of racial justice work. 2) How do white healthcare providers experience racial justice work in healthcare? This question seeks to understand the thoughts, feelings, motivations, or sense of racial justice work that white healthcare providers endorse.

The following paragraph provides a roadmap of the discussion for the dissertation. Chapter One: Introduction introduces the research, the rationale, the research terms, and the research question. Chapter Two: Theoretical Orientation and Conceptualization introduces my theoretical framework, integrating Critical Race Theory and Critical Whiteness Studies. Chapter Three: Literature Review of the Research Area examines the health inequities of Black people. Chapter three demonstrates that anti-Black racism and health inequities for Black people outpace

other groups (Phelan & Link, 2015), and Black healthcare providers' representation lags behind most racialized groups (Poole & Brownlee, 2020). Chapter Three interrogates racism in the healthcare field, interventions for health inequities, and gaps in the literature around white healthcare providers involved in racial justice work. Chapter Four: Methodology and Research Design describes phenomenology's congruency with my research topic and critical theoretical framework. Chapter Four discusses my research design, data collection and analysis methods, and ethical considerations. Chapter Five: Findings present the themes and sub-themes that emerged from the data. Finally, Chapter Six: Discussion and Conclusion offers the analysis and interpretation of the data, the study's implications, and the conclusion.

Conceptualization and Operationalization of Terms

As Chapter Two explains, fundamentally, this research implicates the significance of race, racism, and white supremacy within healthcare and the enduring influence of racism and white supremacy on health inequities. Next, I explain how I conceptualize and operationalize the terms in my research. To establish a shared understanding of "health," I utilize the definition from the World Health Organization (WHO; 1946, p. 1): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Within my research, I conceptualize work to eradicate health inequities among racialized people as "racial justice work." I operationalize *racial justice work* within the healthcare field as activities (indicated by the study participants) designed to tackle racial injustice on behalf of racialized people. This will allow the investigation to capture the broad scope of racial justice and address a gap in the literature. I conceptualize w*hite healthcare providers* as people who self-identify as white and work as scientists/providers in healthcare, including doctors, nurses, and social

workers. The "*healthcare field*" is operationalized for my research as social work, medicine, nursing, and health-related science.

Race is a social construct with historical, legal, material, psychological, and temporal advantages and disadvantages for certain groups usually designated by phenotype (Du Bois, 1920; Omi & Winant, 2019; Roberts, 2011; Zuberi, 2001) politically created from and maintained by racism. Racism is an "ordinary" part of the experiences in the lives of most people of color and permeates every system in society. Codified into law, it often presents in "white over-ascendancy (Roberts, 2011)." White supremacy is the social, political, legally sanctioned, and physically and psychically violent racial power structure. It originates from Eurocentrism and colonialism (Mills, 1997; Yancy, 2017) and is maintained through a system of whiteness that imbues implicit and explicit admission, power, property, and privilege to individuals and institutional rewards and punishments according to group or individual location along the continuum of the embodiment of "being" Black or "being" white (Ahmed, 2007; Baldwin, 1985; Du Bois, 1920; Fanon, 1952; Harris, 1993; Leonardo, 2013; Roberts, 2011).

Group Characterizations Used in the Data

In historical and modern society, all people are racialized in different ways, white, Black, Brown, and other specific groups of people of color. As established by the researcher and study participants, when the term "racialized" is used for this study, it refers to Black or Brown people. Therefore, when participants throughout the data reference "racialized" people, they are referring to Black or Brown communities or people.

Significance of the Research for Social Work

Historically, racism and white supremacy in social work exist alongside the professed social justice mission of social work. The next section describes the antithetical tension within

social work and the significance of the research for social work as a part of allied health professions. The following discussion places the research within the social justice mission of social work and social work as an allied health profession.

The following section contextualizes my research question within the philosophy and history of social work. I situate the discussion of the philosophy and history of social work within the social justice mission of social work and social work's involvement in healthcare. Next, I explore the significance of white healthcare providers involved in racial justice work to the profession of social work, examine whiteness and the helping imperative in social work, and conclude with a chapter summary.

Social Justice in the History and Philosophy of Social Work

Defining Social Work

Social work is "a profession that assists individuals, families, groups, and communities in enhancing their individual and collective well-being" (Drover, 2019, p.1). North America's social work organizations express goals to promote the welfare of people with particular attention to the needs of those who are vulnerable and oppressed (Canadian Association of Social Workers [CASW], 2005; National Association of Social Workers [NASW], 2017). The International Federation of Social Workers (IFSW) offers the following as part of their 2014 definition of social work: "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people (IFSW, n.d., para. 1)." The definition of social work has changed over time. Professional social work bodies like NASW, CASWE, CSWE, and the IFSW create different iterations as the associations face pressure and challenges from their memberships.

There are critiques about the universality of a standard definition for social work. Social work embodies different meanings and practices across spatial, cultural, and temporal locations (Finn, 2021). For instance, African-centered social work draws on a "paradigm based on the idea that African people should reassert a sense of agency as a foundational step to achieving liberation within the context of oppression (Dyson & Brice, 2016, p. 109)." This doctoral research centers on an aspirational definition of social work drawn from African-centered social work, defining social work within an oppressive social context as an ongoing call to liberatory practice (Bernard & Smith, 2018; Schiele, 2017) that should be transformational, critical, and political (Finn, 2021).

Defining Social Justice

Social justice has been a "professed" value and objective of social work for over one hundred years (Reisch, 2019). The definition of social justice has varied across time and space (Finn, 2021; Reisch & Andrew, 2002, 2007, 2008, 2017; 2019). Social Work historians such as Reisch and Andrew (2002) offer the following summation of the origins of social justice relevant to this discussion. Early philosophers like Plato broadened the meaning of justice by linking it to human well-being; "justice" gives individuals what they deserve based on their station in life. For Plato, class distinctions were needed to maintain social order, and "justice" ensures that these "institutions" continue functioning as intended. Similarly, Aristotle believed there must be a hierarchy in society; he added that the "law" would maintain justice and only viewed white men who owned property as worthy of equality and justice (endowing only white men with the power to make the law). Neither Plato nor Aristotle saw individuals as inherently equal, and both sanctioned inequality; Aristotle's

view provided the justification and sanction for enslavement and oppressive practices dictated by white men (and thereby white women).

Social justice has changed from being about specific groups of people achieving recompense from oppression; instead, the meaning now flows from ideas of equal rights or liberty to policies about the respective duties and required functions of individuals and the community (Reisch & Andrew, 2002). Additionally, social (in)justice "is contingent on a complex interplay between philosophical and political arguments about human nature, rights, moral principles, and political and economic theories (Watts & Hodgson, 2019, p. 10)." At the same time, ideas of justice are typically "abstract ideals" centered on our beliefs about what is "right, good, and desirable" (Finn, 2021, p. 94).

> As it has been for millennia the concept of social justice is now used as a rationale for maintaining the status quo, promoting far-reaching social reforms, and justifying revolutionary action… liberals and conservatives, religious fundamentalists, and radical secularists all regard their causes as socially just (Reisch & Andrew, 2002, p.343).

There is little agreement "about the balance between social justice (rights to social benefits) and equality (obligations to individuals or groups)" (Reisch, 2019, p. 124).

Social Justice as An Aim for Social Work

Social work scholars do agree that in North America specifically, conceptions of social justice morph according to political, social, and cultural understandings (Finn, 2021; Reisch & Andrew, 2002, 2019). However, social work as a profession does profess a goal of social justice, with many social workers ascribing to the notion that social "justice" work should be operationalized through transformational, critical, and political principles (Finn, 2021). The

IFSW embraces the quest for justice-oriented social work practices as part of its core definition of social work:

> …Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance well-being (IFSW, 2014, para. 1).

The American Academy of Social Work & Social Welfare (AASWSW; 2019) includes the quest for equal opportunity and justice as one of its 12 grand challenges. The AASWSW determined that addressing racial and social injustices was the pathway to realize this challenge.

In social work, the aim for social justice is often connected to terms such as freedom, liberty, equity, equality, access, and fairness (Banerjee, 2011; Bhuyan et al., 2017; Hudson, 2017; Reisch & Andrew, 2002). Though the definitions of social justice vary, fundamentally, Western philosophy, political theory, and Judeo-Christian values undergird the ideas of social justice in social work (particularly in the U.S.; Finn, 2021; Reisch & Andrew, 2002). The "concept of social justice in Western societies has influenced contemporary social welfare" (Reisch 2002, p. 343). Therefore, as the next section will demonstrate, the actuality of social work's goal for social justice (specifically in the U.S.) has often been circumscribed and delivered based on personal beliefs and the sociopolitical context of the era in which it is delivered.

Examining Social Justice in Social Work's Past. The following examination of the distinct eras of social work development highlights the evolution of social justice as an aim of social work. According to social work historians, building on the themes of Plato and Aristotle, philosopher Thomas Hobbes' views of social justice are apparent in the delivery of social work

during the 17th and 18th centuries (Reisch & Andrew, 2002). Hobbes proposed the idea of the "state" as the collective desires of "just" people and, thereby the authority in sustaining a just society. Hobbes' take on justice can be seen throughout the following sections that describe the development of social work from the colonial period to contemporary social work (Reisch & Andrew, 2002).

During the Colonial period, 1607-1783, the need was initially met with mutual aid characterized by humanitarianism and the awareness of white people's susceptibility to impoverishment. As systems became more formalized, colonizers adopted the English Elizabethan poor laws, dividing people experiencing poverty into the "deserving and underserving," and instituting "settlement laws," which created control over assistance, determining where groups could receive assistance and the duration of benefits (Cox et al., 2019, p.27; Fortier & Wong, 2019; Wagner, 2005). The move from the universalism of suffering and need to hierarchal worthiness of need ties North America's social welfare system to the imperialistic values of England and an emerging system of whiteness, which marked those who were "different" (Dumbrill & Yee, 2019). The deserving poor were considered "good" people temporarily needing help, while the undeserving poor were those making bad choices, who could do better if they desired. The Enlightenment period ushered in liberalism, which grounded social justice in individual freedom and justified social inequalities through "universal" scientific narratives that were deemed "factual" and became codified into law (Reisch, 2014).

During the Industrial period, from 1784 to 1890, the "social gospel movement" influenced social welfare efforts, advocating for Christian principles to social problems and social reform. Social advocacy began to take shape, advancing more humane treatment for whites, namely children, recent immigrants, and mentally ill people (Senteio & Matteucci, 2017).

In addition, a system of substantiating need through record-keeping began. The systematization of care led to "investigation and registration" of need (Heyman & White-Ryan, 2018). Based on Christian beliefs and the view of poverty as an individual deficit, this period also heralded the following two movements: The Charity Organization Society (COS) emerged with its "friendly visitors," who eventually became paid social welfare agents, precursors to modern social workers (Margolin, 1997). Also, the Settlement House movement began, placing services within the recipient's community, a precursor to modern community based social work (Cox et al., 2019, p. 28). These movements continued into the Progressive era, 1890-1920, during which societal changes necessitated more formalization of social welfare through social work education and the professionalization of social welfare services (Flexner, 1915; Wenocur & Reisch, 1989).

In the United States, vestiges of changes implemented during this period are still evident in spending appropriated for social programs, social "control" attached to social beneficence, the judgment of deserving and undeserving based on dominant group values, the connection between "work" and assistance for the undeserving poor, and the shaming and disparate treatment attached to the "undeserving" (Cox et al., 2019, p. 28). The common thread woven through each era is the sociopolitical context in which social work is delivered. This trend continued into the next era. From World War I (WWI) until the Great Depression, the profession was targeted by the government and others with accusations of communism, causing visible social activists to lose their jobs (Jennissen & Lundy, n.d.). Threats during the "Red Scare," political accusations of an association of social "welfare" and "advocacy" with communism and socialism, caused some social workers to retreat from fighting against injustice (Reisch & Andrew, 1999; Social Welfare History Group, 2023). The cultural hegemony that worked to sustain the status quo left an indelible mark on the profession during this era. Many in the profession retreated from fighting

against injustice to fulfilling its policy-stipulated role and the individualization of problem-solving. Liberalism continued to impact the social work mission for social justice during this period. Liberalism interjected the "freedom" through which individual social workers could choose the values and morals they ascribed—even if those values differed from those officially promoted in social work (Clifford, 1982). The incongruency for social work practice here is when conflicting values joined with the societal mores that furthered injustice.

Examining Contemporary Social Justice in Social Work. Major themes of each era demonstrate the consistency of the historical ambiguity of claiming a "mission" of social justice but lend clarity and validation to the claims of white supremacy since the inception of social work (Bowles & Hopps, 2014; Gregory, 2021). Social work consistently reflects society's social, political, and moral convictions (Drover, 2019). From WWII to the Civil Rights era, fluctuations in social advocacy continued, though social work made some social justice gains. For instance, the U.S. did witness the profession's importance; a social safety net was established, and as anti-discrimination legislation was passed, social welfare programs began to provide service to Black people (Cox et al., 2019). Still, one could argue that these gains were not because of social work's leadership but because of the widespread unrest that predicated the various movements of the historical eras (Schiele, 2011).

As later discussion will illuminate, social work's response to racism and the plight of Black people has been slow at best. For example, the social work profession was slow to join the struggle for civil rights (Reisch, 2017). Likewise, in the most recent dual pandemics of racism and COVID-19, which disproportionately impacted Black communities (Murray-Lichtman et al., 2022a), social work had to be *pushed* to move past declarative statements (Murray-Lichtman & Elkassem, 2021). In 2021, the profession answered the call of social justice activists and racial

justice scholars (see Elkassem & Murray-Lichtman, 2022; Murray-Lichtman et al., 2022a) who protested inaction in the face of the racial injustice illuminated by COVID-19 and the police murders of Black people. The Council on Social Work Education (CSWE, 2021) formed the national Task Force for Anti-racism (of which this writer was a member), which ultimately suggested updates to the CSWE's Education, Policy, and Accreditation Standards. Until forced to go beyond performative statements, two *social justice* initiatives, the Civil Rights struggle and the dual pandemics of COVID-19 and racism, caught social work sitting on the sidelines.

Scholars suggest that social work's heavy reliance on the Rawlsian concept of social justice for *all citizens* does not allow for a process to tackle systems that perpetuate inequities or to dislodge the notions of *who* deserves help (Banerjee, 2005, 2011). In the Rawlsian model of social justice, most disadvantaged people, including those with health and psychosocial needs, do not fit as they do not meet the mark as "citizens"—those deserving and capable of contributing to society (Banerjee, 2011). Contemporarily, social justice in social work is full of ambiguities despite the social work professional bodies having social justice claims (Finn, 2021). Although social justice may be explicitly stated in the mission of social work, the performance of social justice in social work is much less explicit—lacking clear-cut policy statements or practice directives (Issahaku, 2019). Social work scholars agree and find that, in fact, at times, "social justice" in social work is contradictory and may conflict with other goals (Bhuyan et al., 2017); Deepak et al., 2015; Finn, 2021; Issahaku, 2019; Reisch 2019). Other social work scholars argue that social work has abandoned its mission (Specht & Courtney, 1995). Scholars argue that in social work, "representations of social justice may operate as an institutional value while institutional practices simultaneously reproduce racial and other societal hierarchies (Bhuyan et al., 2017, p. 375)."

Given the discrepancies, it is not surprising that social work falls far short of its social justice goals (Banerjee, 2011). Social justice in social work is largely performative, and practical social justice skills are ill-defined (Bhuyan et al., 2017). Murray-Lichtman and Levine (2018) agree that without explicit social justice training, future practitioners risk maintaining the status quo rather than facilitating social justice. Social work mainstreamed and institutionalized social justice rhetoric but not social justice practice (Bhuyan et al., 2017; Hawkins et al., 2001). Ahmed (2006, 2016) calls this making "speech acts" or performative statements that do not produce the effect or action they claim. Instead of clear and actionable social justice practice skills, social work has done little to change structural injustices that impact the lives of individuals (Atteberry-Ash et al., 2019; Bhuyan et al. 2017; Deepak et al., 2015; Dominelli, 1997; Elkassem & Murray-Lichtman, 2022; Murray-Lichtman & Levine, 2018; Reisch, 2007, 2008; Specht & Courtney, 1995).

The profession can claim "a long history of progressive activism directed to individual and social change. At the same time, observers within and outside social work have often accused the profession of serving as a handmaiden of the status quo" (Abramovitz, 1998, p. 512). The historical and contemporary lens of social justice and social work demonstrates how social justice and social work were linked to each period's political and philosophical thoughts. Social work, "since its inception, seems to have been challenged by a "push-pull" or ambivalence vis-a-vis power and powerlessness, wealth and inequality, and social control and benevolence (Bowles & Hopps, 2014, p. 5)." Social work has rarely, if ever, fully engaged its "mission" for social justice; instead, for the most part, it has allowed de jure racism and de facto white supremacy to guide its policy and practice (Beck, 2019; Gregory, 2020; Maylea, 2020; Reisch, 2017).

Social Work's Entrance into Healthcare

Despite the influences of racism and white supremacy, throughout each era, social work expanded its role as a profession concerned with and responsive to the health and well-being of individuals and communities. Developments within the progressive era tremendously impacted the trajectory of social work in healthcare. The most consequential contribution of the Progressive era emerged from the differing perspectives of science and humanism, attributed to two social workers, Mary Richmond and Jane Addams, respectively. Jane Addams, the founder of Hull House, a settlement house, drew attention to the community and social conditions generating needs. In comparison, Mary Richmond began efforts to individualize services by instituting "cases" with an assessment of individuals and documenting their needs that could be measured scientifically. She, along with others, sought professional status for social workers and is credited with applying the medical model in social work (Cox et al., 2019; Reisch, 2012; Wenocur & Reisch, 1989).

Two approaches to social work emerged, each providing an opportunity for social workers to engage in political and social advocacy to change the factors contributing to the plight of the individual. Yet, the two approaches also produced tensions inside and outside the profession that still exist (Goldstein, 1990; Maylea, 2020). Flexner, an influential and self-proclaimed racist concerned with the "professionalization" of various occupations, heavily skewed the directions for several helping professions like medicine and social work. Flexner's (1915) question, "is social work a "profession?" substantially influenced Mary Richmond's quest for "scientific" credibility. This period's winner was the formalization of social work's role within healthcare.

In 1905, the U.S. saw the first full-time hospital social worker joining the physician and nurse team, marking a change in the approach to healthcare (Cabot, 1919; Cannon, 1917; NASW, 1923; Praglin, 2007). Social workers were fundamental in the mission to meet the challenges faced in providing public healthcare (Folks, 1912; Hopkins, 1926). Bartlett (1934) advocated for social work to be involved in all aspects of healthcare and deemed social work's participation in healthcare fundamental to healthcare provision. Bartlett's advocacy fostered social work's establishment of an enduring relationship with healthcare and the concern for the welfare of individuals within the healthcare system (Bartlett, 1934; Black, 1984; Bracht, 1999; Cabot, 1909, 1919; Crewe, 2018; Congress & Heyman, 2018; Folks, 1912; Heyman & Congress, 2018; Heyman & White-Ryan, 2018; Hopkins, 1926; Lewis, 1937; Reichert, 1965; Reisch, 2012; Rosenburg & Rehr, 1983; Ross, 1995; Ruth & Marshall, 2017; Ruth & Sisco, 2008; Sommers, et al., 2000; Thornton, 1923; Woofer, 1923; Zabora, 2011).

Even in precarious times like during the "Red Scare," the profession made gains within healthcare settings, and their roles within healthcare expanded –albeit on precarious footing (Reisch, 2012; Reisch & Andrews, 1999). Cabot (1919) envisioned social workers, unlike nurses, working as equals alongside doctors, providing a view into the social context of the patient's illness and providing effective patient-centered treatment strategies. Guided by this vision, social work's role and contribution to healthcare became more solidified. For instance, during the early 1900s, social work introduced the precursor of the contemporary biopsychosocial assessment that Cabot (1919) and Cannon (1917) had envisioned as being fundamental to a healthcare social worker's role within the hospital setting (Reisch, 2012).

Ironically, while psychiatric social work grew, social work's quest for "science" and the hospital casework model moved social workers in healthcare away from Cabot's (1919) vision of

their status as equal to physicians (Reisch, 2012). Cabot (1919) believed that social workers were the experts in the "social context" and the intersection of the social context to the health and overall well-being of the patient. However, following the model Mary Richmond set forth and in a quest for professional validation, social workers began to model themselves after physicians, fully embracing the hegemony of "science" (Reisch, 2012; Wencour & Reisch, 1989). Social work was also challenged during this period to "prove" the scientific relationship between the individual's social context, the emergence of the illness, and the prescribed medical intervention (Reisch, 2012).

During this stage, several factors in social work coalesced: the individualization of problems and advocacy, weakened advocacy for societal change, and the lure of professional validity via science. These changes heralded benefits and consequences for the profession. For instance, social work saw its role in hospital settings shift and become subordinated under physicians (Webb, 1931). Social workers would continue to be considered healthcare workers, with the distinction between hospital and psychiatric social work (Reisch, 2012). Additionally, the government recognized the need for professional social workers. However, the reduction of social activism to eradicate economic, political, and social conditions that potentiate individuals' problems led to a profession that applied bandages to the issues that it helped to create as the arm of the state (Carten, 2016; Chapman & Withers, 2019; Dumbrill & Yee, 2019; McRae, 2018; Reisch & Andrews, 1999; Schiele, 2000, 2011). Although the profession's embrace of positivist' science,' measuring individual responses to a social phenomenon validated social work and allowed for a continuous flow of data and opportunity for some within the profession.

Significance of White Healthcare Providers and Racial Justice Work to Social Work

Despite brief periods of radical social work, as a profession, social work has walked in lockstep with and mirrored the oppressive systems that dominated the day (Maylea, 2020). The glaring health inequities and injustices faced by racialized people are pressing social workers to respond. Social work must determine "how do we [social work] work in ways that do not further exacerbate already existing health inequities (Walter-McCabe, 2020, p. 69)?" The contextualization of my research within the philosophy and history of social work concludes by examining whiteness in social work and the helping imperative in social work. Whiteness is discussed more thoroughly in Chapter Two. Therefore, I offer two illuminating examples of whiteness in social work relevant to my research.

Whiteness in Social Work

The 1919 National Conference on Social Welfare asked the question, "what does the Negro want in our democracy?" Wright's (1919) response, in a profound speech at the conference, denounced whiteness, saying Black people want "a democracy not a whiteocracy" (Wright, 1919, para. 1). Gregory (2020) wonders if the reason social work has not challenged whiteness within the profession is "that such an undertaking threatens the integrity of social work in a different way than it does any other profession or discipline (p. 1)." For the discussion of whiteness in social work, I utilize Joseph et al. (2019) summation that "whiteness is instituted through constructing organizational space as neutral and natural against bodies that are constituted as sites of difference (p. 175)."

[We] do not want a "whiteocracy." Over a century later, the profundity and continued relevance of Wright's (1919) words for social work is disheartening. Gregory (2020) maintains that "social work in the United States has not taken an honest, rigorous, critical account of its

own whiteness (p. 1)." The ahistorical accounts of the development of social work rarely mention the social welfare leaders within the Black community. While there is a preponderance of historical literature about white social work leaders' service to white people when economic depressions and war impacted white communities, people living on the fringes of society often faced a far more severe existence. Racism and white supremacy meant that Black and Indigenous communities bore the brunt of racialized attacks, harsher social conditions, and fewer resources provided by the state (Carlton-LaNey, 2001; Este et al., 2017; Harty, 2021; Reisch, 2017; Ross, 1978). Social work historians are often remiss in not addressing the whitewashing of the history of social work, which includes the erasure of racism and white supremacy and Black social welfare pioneers (Wright et al., 2021). Despite not addressing these issues, Tascòn and Ife (2020) point out that "social workers talk confidently, and unreflectively, about the 'body of knowledge,' 'knowledge for practice,' 'professional knowledge,' 'knowledge transfer' and so on (p. 1)." Social work built an entire "evidence-based" healthcare body of practice interspersed with and guided by the fallacy of social work's foundational "knowledge," and social work continues to teach future practitioners from the same "knowledge" base (Tascòn & Ife, 2020). "The whiteness of social work is a consequence of the whiteness of its knowledge (Tasscon & Ife, 2020, p. 2)." Examples are the absence of Black and racialized voices in the curriculum and the pushback from social work students and faculty regarding anti-racism and whiteness content (Brice & McLane-Davison, 2020; Jeffery, 2005; Jeyasingham, 2012; Murray-Lichtman et al., 2022a; Murray-Lichtman & Elkassem, 2021).

As white social workers were formalizing their social welfare efforts, Black social welfare workers also organized within their communities, created social work institutions, and trained social work students (Burwell, 1994). They were also taking part in the "struggle for

healthcare" for Black people (Jones, 1923; Thornton, 1923; Woofter, 1923). Self-help has long been a vehicle to care for those marginalized from mainstream resources (Schiele, 2000). Black women's social welfare efforts covered many community needs (Knight, 2017; Lerner, 1972). An examination of the 1900s Coloured Women's Club of Montreal (CWCM) captures the rich history of African-centered values of collectiveness and mutual aid (Este et al., 2017). Similar to this account of the CWCM, the work of the U.S.'s Colored Women's Clubs was, in most cases, the vehicle that empowered the Black community (Carlton-LaNey, 2001). In many instances, Black social welfare pioneers and Black social welfare organizations were the mainstay for their communities, providing denied and often unavailable services (Hall, 1954; Ross, 1978). Also, during this period, "Latino *mutualistas*" and associations created by Asian immigrant communities "infused concepts of mutual aid and self-help into their services (Reisch 2017, p. 4)." These groups, marginalized by mainstream social work, embraced their "cultural heritage" and traditional means of responding to individual and community needs" (Reisch, 2017, p. 4).

Similarly, during the height of the civil rights era in the U.S., predominantly white social work organizations were largely silent about the plight of racialized groups requiring Black social workers to respond to the needs of the Black community. In addition to the silence, the profession was said to operationalize social "welfare colonialism" (Berry, 1989, p.634). The coloniality, silence, and inaction on behalf of racialized groups were also accompanied by active deficit-focused individualization of problems reinforcing the white supremacist order of the day that denied the agency of racialized groups and the structural and systemic racism and white supremacy. For instance, white supremacy in social work negated the strengths of the Black (and other racialized groups') family and, for the most part, failed to enhance their welfare (Brice & McLane-Davison, 2020; Billingsley, 1968, 1973; Carlton-LaNey & Burwell, 2014; Park, 2006)

through racist practices and restrictive definitions of service eligibility, which enforced the primacy of the "nuclear family" as defined by white standards. These racist practices discounted survival strategies in the Black family—which included extended family and fictive kinship structures--forcing a deficit-focused view of Black families and, most importantly, in the face of great need, limited social welfare assistance to Black families (Murray-Lichtman et al., 2022a; Elkassem & Murray-Lichtman, 2022). In 1968, Black social workers denounced the white supremacist and racist deficit focus, silence, and disregard for the Black family of the profession and walked out of the National Association of Social Work (NASW) Conference, forming the National Association of Black Social Work (NABSW), an organization dedicated to serving the needs of the Black community (Jaggers, 2003; Johnson, 1978). The NABSW continues until this day to be a source of refuge for Black social workers, a reminder of the strengths and resourcefulness of Black people, and a site for scholarship and action against anti-Black racism, countering the silence and inaction and white supremacy and racism embedded in the social work profession (Brice & McLane-Davison, 2020; Jaggers, 2003).

Carlton-LaNey (2001) notes that the incomplete account of social work's history is not accidental. The "conspiracy of silence" is part of social work's complicity in societal injustice. These omissions keep invisible a system of social work that has historically shut out "Others," created a caste of second-class citizens, and harmed certain groups more than it has helped while maintaining a racist system under a façade of innocence and goodness (Badwall, 2014; Chapman & Withers, 2019; Margolin, 1997; Reisch, 2017). Moreover, "these communities rejected the equation of social justice with coerced assimilation and paternalistic benevolence and criticized the social work profession for its inability to embrace full social equality (Reisch, 2017, p. 4)." Social work's axiological assumptions of white supremacy and racism influenced (and continue

to control) similar social welfare actions across international borders (Adjei & Minka, 2018; Detlaff et al., 2020). Lest we think that putting historical accounts right redeems whiteness, Jeyahsingham (2012) warns that confronting your own experience of being racist is essential. Still, the embedded system of whiteness remains unchallenged by most white people in social work (Gregory, 2020, 2021; Beck, 2019; Lee & Bhuyan, 2013; Maylea, 2020).

Ahistorical accounts of social work discard certain knowledge; in some instances, white social workers would join Black social workers to fight against racial injustice and for reform in social work services and the broader community. Their support was often their influence on other white people for social, political, or economic support of Black social work efforts (Lerner, 1972). These white social workers stood against the interest of whiteness; they were reformers who joined the struggle of Black social workers in doing racial justice work. For example, Lillian Wald (Social Welfare, n.d.a) and Bertha Reynolds (Social Welfare, n.d.b) were radical for their time, and their actions could be considered racial justice work.

While their work is not totally erased, these two anti-racist white practitioners are rarely cited for the dangerous missions they embraced--their racial justice work in the social work community. For instance, Lillian Wald worked for the social welfare of people experiencing poverty regardless of race. She was moved to action after seeing "all the maladjustments of our social and economic relations" (Social Welfare, n.d.b). She founded the Henry Street Settlement in New York, offering the first interracial community programming, community health care, and place of employment. Wald worked with DuBois as a founding member of the NAACP, allowing the meetings to be held at Henry Street Settlement (Social Welfare, n.d.b). Bertha Reynolds also worked with DuBois in the Atlanta School system and came away with an understanding of the struggle for freedom that Black people faced due to racialization. This

influenced her social reform efforts, her contributions to the strengths perspective in social work, and her critiques of the profession (Social Welfare, n.d.). This list is not exhaustive but illustrates the gaps in most historical accounts.

Social work's historical accounts that do not include pivotal Black leaders and emphasize the anti-racist work of white leaders accentuate the absence of "Othered" bodies from mainstream social welfare and the reification of whiteness within the narrative. Consequently, the lack of historical social work knowledge contributes to an ahistorical approach to contemporary social problems (Reisch, 1988). This revelation of whiteness demonstrates the consistency of the values that underlie the profession and provides an opportunity for self-evaluation and action.

Helping Imperative in Social Work

Similarly, social work's "helping" practices recreate white supremacy and colonialism (Badwall, 2014). Heron (2007) describes the helping imperative as a drive to do work that casts the helper as compassionate, good, and worthy of commendation. Helping is quite laudable; it is beneath the surface that we see how the "us" and "them" narrative influences the characterization of the "Other" and reinforces ahistorical analyses and actions that center the helper. These "colonial continuities" in social work reinscribe upon social workers "innocence," "goodness," and "moral superiority" in the helping relationship (Badwall, 2014; Heron, 2007).

The helper's complicity in the systems perpetuating the needs eludes incrimination (Bussey, 2020; Heron, 2007; Todd, 2011). By centering white ways of knowing and being, the helper's values are the norm that guides the help, and the helper becomes the authority. The discourses of "helping" include civility, which establishes the good, innocent white helper while denying the "difference" of the Other (Badwall, 2014). The needs of the Other are read as

personal and cultural dysfunction and "…by erasing the agency of local peoples who are Othered in these processes, and by presenting 'our' (read white middle-class Northern) knowledge, values, and ways of doing things as at once preferable and right (Heron, 2007, p.3)."

The helping imperative and whiteness are particularly relevant to my research question examining the experiences of white healthcare providers involved in racial justice work. Do whiteness and the helping imperative influence their racial justice work? How have they navigated the terrain of "the helping imperative" in their racial justice work?

Chapter One Summary

Chapter One introduced the research examining the experiences of white healthcare providers involved in racial justice work. Chapter One also placed the significance of the experience of white healthcare providers involved in racial justice work in the historical and present-day philosophy and social justice mission of social work. The chapter explains the research terms and the research questions that will guide the research. The discussion in Chapter One concludes by situating the research around white health care providers' experience with racial justice work within the context of whiteness and the helper imperative, two important themes that continue to manifest in social work.

For us, true speaking is not solely an expression of creative power; it is an act of resistance, a political gesture that challenges politics of domination that would render us nameless and voiceless. As such, it is a courageous act—as such, it represents a threat. To those who wield oppressive power, that which is threatening must necessarily be wiped out, annihilated, silenced.

—hooks, 1989, p. 8

Chapter Two: Theoretical Framework and Conceptualization

In this chapter, the exploration of Critical Race Theory (CRT) and Critical Whiteness Studies (CWS) underscores their relevance for the experiences of white healthcare providers involved in racial justice work. CRT and CWS offer a pathway to theorize and conceptualize the experiences of white healthcare providers involved in racial justice work. CRT and CWS are contextualized within the contemporary and historical framing of race, racism, and white supremacy. The discussion focuses on the manifestation of racism and white supremacy within the U.S. to situate the structural manifestations of race, racism, and white supremacy within healthcare.

The chapter begins with a discussion of critical theory as a vehicle to seek health equity for Black people. The discussion interrogates the current social and political debate over race, racism, and white supremacy. Next, the discussion draws the similarities between the present debate and the social circumstances from which CRT and CWS emerged, explaining the historical underpinnings of CRT and CWS and their development. Finally, the chapter ends with an exploration of each theory and fundamental tenet relevant to critically examining the experiences of white healthcare providers involved in racial justice work.

Critical Theories as a Transformative Framework for Research

My philosophical assumptions are grounded in a critical and transformative framework that prompts my query into health equity for Black people. Therefore, my theoretical lens is also critical (Creswell, 2007). I utilize the lens of Critical Race Theory (CRT) and Critical Whiteness Studies (CWS) to understand and frame my research topic (Graham et al., 2011). CRT allows me to understand my substantive area through the lens of the permanency and pervasiveness of racism and to unveil the counter-stories of racial justice work (Alcoff, 2017; Bell, 1995; Crenshaw et al., 1995; Delgado-Stefancic, 2001; Du Bois, 1935; Graham et al., 2011; Ladson-Billings, 2003). CWS allows me to understand and interpret my research through the lens of whiteness, a set of systemic material, psychic, and social advantages and disadvantages born of racism and white supremacy that are self-perpetuating and resistant to change (Ahmed, 2007; Baldwin, 1985/2008; Bell, 1995; Bonilla-Silva, 2018; Du Bois, 1920; Fanon, 2008; Feagin, 2013; Frankenburg, 2003; hooks, 1992; Kincheloe et al., 2000; Morrison, 2019).

Critical theorists approach research with the understanding that the "objective" reality of oppression is filtered through the researchers' values and knowledge. The critical theorists' research goal is to embrace and incorporate these values transparently to produce emancipation and transformation through research (Creswell & Poth, 2017; Denzin & Lincoln, 2018; Maglalang & Rao, 2021; Morris, 2006; Rubin & Babbie, 2016).

Contemporary Contextualization of Critical Race Theory and Critical Whiteness Studies

After the 1960s civil rights movement and then again with the 2008 election of President Barack Obama, the conversation circled to the "post-racial" society that affords anyone, regardless of their "race," all of the opportunities they desire. The post-racial discussion flew in the face of the staggering statistics of inequities across systems and the health inequities that

disproportionately impact Black and Brown bodies (Alexander, 2012; Allen & White-Smith, 2015; Calero et al., 2017; Donner& Ladon-Billings, 2018; Feagin & Bennefield, 2014).

Alarmingly, a re-enactment of the post-Civil Rights era that has ramifications for healthcare (social work, nursing, and medicine) is happening in plain sight (Roberts, 2021). Recent events like the January 6, 2021, insurrection in the U.S., the power grab of white political officials and voter disenfranchisement aiming for minority white rule, and the rise of overt acts of violent white supremacy around the country (Gilbert, 2021; Levitsky & Ziblatt, 2020; Ray, 2021) bring the post-Civil Rights era and the onslaught of overt white supremacy full circle (Segrest, 1994/2019). In the months following the formation of a racial justice coalition in the U. S. after George Floyd's murder (Brown, 2020; Hargrove, 2021; Haynes, 2020), "white rage" (Anderson, 2016) invoked attacks against anti-racism through a cascade of activity ranging from bans on equity training by Trump (NPR, 2020), an assault on CRT (Crenshaw et al., 2021; Ray & Gibbons, 2021), protests at secondary schools and death threats against school board members (NBC, n.d.; Feuer, 2021); book banning across the U.S. (NPR, 2021); Black history and other course information changed (Atterbury, 2023); to increased white supremacist marches and demonstrations (Marcus, 2023).

The judicial backlash and other racist events are not coincidental (Anderson, 2016; Crenshaw et al., 2021). Crenshaw et al. (2021) state that the animus against CRT is a catch-all for anything that can dislodge the racial justice movement and anti-racism action. In fact, despite the momentum and the mutual goals established in 2020 by a broad (multi-racial) coalition, racial justice is under attack. The same "white rage" has occurred after every racial justice gain in the U.S. from Reconstruction to the *Brown v. Board of Education* integration of schools (Anderson, 2016). White supremacy's age-old fissures created by the "racial contract"—

designed to separate and entrench people along the lines of race (Mills, 1997) dismantled each racial justice gain, rolling back progress. Therefore, the call for healthcare and those concerned with health inequities is not just for speech acts (Ahmed, 2006, 2016) but an urgent conviction to *act* like Black lives hang in the balance (Bailey et al., 2020; Baldwin, 1985; Bell, 1987, 1992; Yancy, 2014, 2017). The next section of the discussion explains the history of the racial contract, providing the foundation for discussing the history and development of CRT and CWS.

Historical Underpinnings of Critical Race Theory and Critical Whiteness Studies

White Europeans constructed the concept of "race" to justify their global tyranny (Dumbrill & Yee, 2019). The "racial contract" coined by Charles Mills (1997) refers to the global racist social contract that emerged. The racial contract is the shared social understanding of formal and informal white supremacist rules that define, structure, and guide people socially constructed as white and people socially constructed as non-white. The racial contract's innovation was a hierarchal system of racialization valuing whiteness as superior, marking a racial line between whites and Others, and devaluing Black people as most inferior. Through the slaughter of Indigenous communities, chattel enslavement of African people, Jim Crow, and contemporary racism, the racial contract designated non-white bodies as property, deficient, child-like, and subhuman and white bodies as human (Dumbrill & Yee, 2019). The racial contract imbued a claim of moral and sociopolitical white superiority, and the appropriation and exploitation of treasure and land occurred with white impunity. Despite its evolving nature, the enduring goal of the racial contract remains the same, white supremacy. The racial hierarchies in the institutional and structural underpinnings of the U.S., from the political arena to healthcare, demonstrate the contemporary evidence of the racial contract.

History of Critical Race Theory

CRT emerged as a response to the frustration produced by the lack of progress from the U.S. Civil Rights Movement of the 1960s and 1970s (Bell, 1995; Crenshaw et al., 1995). Despite brutal battles, a system emerged from the Civil Rights era that defined racial justice and "racial power" in ways that identified white supremacy as intentional, overt "individual" acts of racial injustice versus a definition including the "color-blind" legal systemic racism with white over ascendancy (Crenshaw et al., 1995; Leonardo, 2004; Peller, 2016). The conciliatory conservative approach pacified progressive and conservative liberals during the Civil Rights era by removing critical race consciousness and making change more palatable (Peller, 2016). However, it paved the way for race-based ideologies without explicit racial language (i.e., dog-whistle politics of bussing, "election fraud," and fights against affirmative action [which benefitted white women more than any other group, Crenshaw, 2010]). In addition, race "neutral" language became the norm, with conversations about race, specifically racism, seen as deliberately incendiary and false or "expecting too much too quickly (Peller, 2016)."

From the foundation of generations of thought leaders, critical legal scholar and former civil rights lawyer Derrick Bell demonstrated that the legal and judicial process systematically disenfranchised and discriminated against Black people and other people of color. In the late 1980s, critical legal scholars Derrick Bell, Alan Freeman, Richard Delgado, Gary Peller, Kimberlè Crenshaw, Mari Matsuda, Cheryl Harris, and others joined together and generated a theory that problematized the centrality of race and the pervasiveness of racism in systemic social inequities (Bell, 1995; Crenshaw et al., 1995). While scholars developed CRT to address legal issues, CRT's underpinnings encompass social, legal, political, and economic issues impacting racialized people (Delgado & Stefancic, 2001/2017). CRT became an interdisciplinary

framework to interrogate outcomes and access across systems that disproportionately disadvantage racialized people (Ladson-Billings & Tate, 1995; Constance-Huggins, 2019; Kolivaski et al., 2014). Derrick Bell and other critical legal scholars, including some white voices, but mainly Black and other scholars of color, stood on the shoulders of prior generations to trouble racial injustice and problematize the dominant racial narrative (Crenshaw et al., 1995).

Tenets of Critical Race Theory

There are several variations of CRT tenets in the literature. The integral component is the action orientation of CRT, creating a theoretical orientation that goes beyond describing phenomena and moves to transformative actions. The tenets of CRT used in this discussion are the following (Bell, 1995; Crenshaw et al., 1995; Ladson-Billings & Tate, 1995; Delgado & Stefancic, 2017): 1) ***Racial realism, interest convergence, and material determinism*** hold that race is a social construct with political, material, and psychological benefits/consequences assigned to racial categories. Racism is pervasive and permeates every social system, and when it is in white people's material interest, they will converge their interests with Black people or other racialized groups. 2) ***Critique of color-blind liberalism*** asserts that liberals (both conservative and progressive) employ the strategy of "not seeing race," and most insidious is the idea of anti-racism as "not" bringing race into the discussion. Equating conversations about race or racism with divisiveness disallows rectifying historical wrongs. It also makes racism a thing of the past and furthers white supremacy and racism in modern systems. CRT claims liberals also embrace "small incremental steps" for change that are not "disruptive" to systems and are typically easily dismantled in court. 3) ***Differential racialization*** socially constructs individuals into racial categories. These categories change over time according to the material needs of white people. This strategy has been used throughout modern history in the U.S. to converge other

racialized groups' interests with the interest of whiteness. As the system of white supremacy morphed throughout history, so did racialization, pulling certain bodies into whiteness and denying admission to others. At the same time, the consistent theme has been the permanency of anti-Black racism (Bell, 1992, 2000). 4) ***Counter-stories of lived experiences and revisionist history*** call for the replacement of majoritarian white supremacist narratives with counter-stories of contemporary and historical events that highlight the struggle, success, and strengths of racialized and anti-racist people. The counter-story presents a contrasting story that seeks to disconnect people from the dominant narrative. It is not *just* a personal story of those victimized by racism and white supremacy; the counter-story is a vehicle for racial justice principles and actions that subvert and disrupt racism and white supremacy (Ladson-Billings, 2013). The counter-narrative then produces an opportunity for oppositionists or "outgroups" to injustice, meaning "any group whose consciousness is other than that of the dominant one, to…subvert that ingroup reality" (Delgado, 1989, pp. 2412-2413). 5) ***Intersectionality and anti-essentialism*** engage the levels of power, privilege, or oppression individuals' different identities hold; it also warns that because this power dynamic may create different interactions within systems, it is vital not to assume everyone's experience of a phenomenon (i.e., racism or sexism) is the same.

History of Critical Whiteness Studies

Critical Whiteness Studies flow from the thought leaders and tenets of Critical Race Theory (Baldwin, 1985; Du Bois, 1920; Bell, 1995; Crenshaw et al., 1995; Delgado & Stefancic, 2001/2017). CWS focuses on studying white people and the self-perpetuating and invisible practices of whiteness (Hartmann et al., 2009). CWS unveils the system of whiteness, but the unveiling alone does not change it (Ahmed, 2007). Scholars across disciplines address the presence of whiteness (Dyer, 2005; Hartmann et al., 2009). Whiteness is the systemic, legal,

material, and psychic manifestation of white supremacy (Du Bois, 1903,1920; Wright, 1940; Morrison, 2019). CWS interrogates the implicit assumptions of whiteness as universal and white people as innocent and good. It also challenges white people in their complicity in white supremacy and denial of their role in the historical and contemporary abuses and economic exploitation of white supremacy (Lopez, 2006; Lipsitz, 2018; Roediger, 2007; Yancy, 2017). Whiteness is a system of oppression that grants access to specific groups of people at certain times according to what is in the best interest of whiteness (Ignatiev, 1995; Roediger, 2007). The proximity of the social location that a body or group of bodies has to the role of the oppressor (Dumbrill & Yee, 2019) determines the power and privilege it holds (Bonilla-Silva, 2018). Finally, the authority and normalcy of whiteness can be passed down generationally as an inheritance (Bilge, 2013).

The Tenets of Critical Whiteness Studies

While there is a significant amount of scholarship on CWS, there is less consensus around the tenets of CWS in the literature. The literature does provide a synthesis of the role of white supremacy, whiteness, and white people. The structural and systemic impact of white supremacy on healthcare is explored in Chapter Three. Here, they are woven within the tenets of the CWS. The tenets of CWS used in this discussion are the following: 1) ***White habitus*** or racial habitus (Bilge, 2013; Bonilla-Silva, 2018) refers to the racially segregated social and spatial locations most whites inhabit. It also explains the socialization structure that conditions white people to understand history and themselves in specific ways, reproducing white supremacy (Bilge, 2013). This marks the geopolitical, physical, and psychic socialization to whiteness as a system of preferences, perceptions, emotions, and white over ascendancy (Bonilla-Silva, 2018; Frankenberg, 1993). Whiteness is an unmarked *habit* or way of being temporally and spatially,

and an ongoing and unfinished form marking some bodies and not others (Ahmed, 2007; Bell, 2000; Dyer, 2002; Fanon, 1952). 2) ***Possessive investment in whiteness*** (Lipsitz, 2018) refers to power, active agency and investment, and social choices that one makes, including areas chosen to live, career choices, political choices, and social systems supported. White and non-white people can be active agents of whiteness, profiting from the hierarchal system of rewards for insiders and exclusion for those who are not admitted to whiteness. Whiteness shifts and recedes with no distinct form except according to its whim—letting in or pushing out bodies, policies, and norms at will (Leonardo, 2004; Leonardo, 2013). Non-white people complicit in white supremacy as demonstrated by their choices often serve a function of "proof" that "whiteness" is the neutral, normalized, and accepted way of doing and being--- and may serve as gatekeepers to exclude other non-white individuals (Ignatiev, 1995; Murray-Lichtman & Elkassem, 2021). One may engage in the discourse of anti-racism, claim to be "anti-racist" or color-blind non-racist but not actively interrogate complicity in white supremacy or engage in activities or politics that oppose social structures that value whiteness, devalue "othered" bodies, and reward racism (Applebaum, 2006, 2010, 2015; Matias et al., 2014). 3) ***Declarations of whiteness*** (Ahmed, 2004) refers to six whiteness declarations that serve as the non-performativity of whiteness: Declaring whiteness is unseen, unmarked, and invisible; therefore, not there. Declaring the fault and the remedy of racism is outside the self. Declaring the shame of racism allows invisibility, absolves the self, and puts racism outside the self. Declaring happiness because one has admitted racism as a juxtaposition to racist people who are sad. Declaring that one has knowledge about whiteness and can see privilege; therefore, one is not racist. Declaring whiteness as colored and, therefore, whiteness is no longer tied to white skin, and the power and domination attached to white supremacy no longer exist. 4) ***Double-edged sword of whiteness*** (Baldwin, 1962, 1984)

refers to the anguish of whiteness socialized (by religion, school, and society) to believe its power and greatness (Du Bois, 1920, 1935; Fanon, 1952) and sees itself in the continued downward spiral after believing the myths of white supremacy; the anger realized when the “privilege” of white skin could not reap enough benefits and power; the longings denied are the fault of the Other (i.e., economic suffering, zero-sum game of healthcare) and cause white people to side with whiteness even when it is against their personal interest (McGhee, 2021; Metzl, 2019). 5) ***Whiteness as property*** (Du Bois, 1935; Harris, 1993) refers to whiteness’s material, psychological, social, legal, and political benefits. Whiteness also gives the rights to innocence, goodness, and universality as distinct attributes to white people (Sullivan, 2014). These benefits are such that they can be inscribed whether or not one participates in white supremacy—they are ascribed to white people as benefits of their skin (Mills, 1997). Finally, ownership of whiteness entitles white subjects to commit the daily acts of domination (decisions, practices, and policies) that make privilege possible (Leonardo, 2004).

Connections Between CRT and CWS

CRT was instrumental in the genesis of CWS. CRT and CWS are linked by ***racial realism and racism,*** which are undergirded by a system of ***whiteness*** to maintain ***white supremacy.*** The theories robustly interrogate institutionalized and interpersonal dynamics of power that define knowledge and practices. They investigate individual everyday white agency in racism and white supremacy, which holds up systems of white structural domination.

Contextualization of white Healthcare Providers involved in Racial Justice Work

My assumption that certain tenets of CRT and CWS are linked and overlapping within the issue of health inequities impacting Black people and white healthcare providers’ racial justice work guided me to the research and informed my literature review. CRT and CWS bring

to bear the intractability and invisibility of whiteness (Dyer, 2005) and how white supremacy produces race and racism that undergird the prevalence of health inequities. Borrowing from these tenets helped me to understand the experiences of white healthcare providers involved in racial justice work who make whiteness “strange” (Dyer, 2005, p. 12) by rejecting racism and white supremacy. In a system in which whiteness exists across the board and is presumed and maintained at the same time that it is contended and countered (Maher & Tetreault, 1998), those opposing white supremacy must continuously disrupt and divest. These oppositioners and outsiders (Delgado, 1989; Ladson-Billings, 2013) produce counter-narratives of social reality that contradict, transgress (Collins, 1986; hooks, 1994), and expose “antithetical knowledge” (Said, 1997, p. 157), ultimately subverting (Crenshaw et al., 1995) dominant narratives of the causes of and remedies to health inequities. CRT and CWS provide a way of explaining racism and white supremacy and contextualizing the struggle of bodies that are harmed and those that work on behalf of racial justice.

Chapter Two Summary

Chapter Two provides an overview of CRT and CWS and the overlapping tenets contextualizing white healthcare providers involved in racial justice work. The discussion of the tenets provides a framework for understanding how white healthcare providers enact racism and white supremacy and how they may counteract racism and white supremacy in healthcare. The chapter ends with exploring how white healthcare providers may conceptualize and situate themselves and their counteractions to racism and white supremacy in healthcare.

Between me and the other world there is ever an unasked question: unasked by some through feelings of delicacy; by others through the difficulty of rightly framing it…How does it feel to be a problem?

—Du Bois, 1903/1986, pp. 1-2

Chapter Three: Literature Review of the Research Area

Although many white people had an awakening during the height of the dual pandemics to the health inequities crisis and the racial injustice many Black people face (Murray-Lichtman et al. 2021), racism and white supremacy are still active in healthcare. The past few years of anti-racism scholarship and activism within healthcare can easily become swallowed up and forgotten by people who are not impacted by the crises. "Health inequity is not a historical accident. Rather, it is a result of policies and practices structured and maintained over time (AMA Staff News Writer, 2021, para. 1)." The policies and processes that have institutionalized white supremacy and racism in healthcare still exist and self-perpetuate.

This chapter begins with an exploration of the relevant findings from the literature regarding systemic racism in healthcare. Unpacking the incongruency between the professed goals and actions of medicine, nursing, social work, and health-related science aids the research. Next, the literature review explores the impact of racism in healthcare on racialized individuals and society. From there, a discussion of the relevant findings in the literature regarding interventions for health equity and an analysis of the efficacy of the interventions for health equity provide key insights into needs within healthcare. Finally, this section concludes with an exploration of white allies who have worked for racial justice and the gap in the literature around white healthcare providers involved in racial justice work.

Research Context Health Inequities and Racism

Systemic Racism in Healthcare

The literature review and discussion in this section examine Black people's healthcare experiences within the U.S. While other racialized groups experience racism in healthcare (Medlock, 2019), the enduring theme in the U.S. is the systemic injustice against Black people (Feagin, 2013). Eurocentric positivism entrenched the belief of "objectivity" and "scientific inquiry" in U.S. healthcare through the "medical model," which determines the etiology of disease and cure within biological causes, ignoring the socio-political influencers of poor health (Medlock et al., 2019). From its foundations in medicine, nursing, social work, and health-related science, healthcare personified the sociopolitical and economic values of the era (Bailey et al., 2021; Drover, 2019; Medlock, 2019; Schroeder & DiAngelo, 2010). White supremacy and racism were two values that informed research and science since healthcare's inception (Medlock, 2019; Weidman & Jackson, 2005).

History of Racism in Healthcare

"The present differences in mortality seem to be sufficiently explained by conditions of life (Du Bois, 1906, p. 276)." Over one hundred years ago, W.E.B Du Bois (1899/2013), in a landmark mixed methods research study, found that the focus on perceived deficits of Black individuals and communities perpetuates the individualizing of health inequities and masks the structural and systemic racism in healthcare (Du Bois, 1899/2017). "The *Philadelphia Negro* advances both a framework for studying the black community and a powerful sociological—not biological, nor psychological, nor otherwise victim-blaming account—of the factors causing black disadvantage (Bobo, 2013, p. 42)." The brilliance of W.E.B. Du Bois' (1899) study and production of irrefutable evidence stand in stark contrast to the era's violence and the terrorizing

use of "science" and healthcare to harm Black people for the good of white people (Bailey et al., 2021; Bobo, 2013; Morris, 2015, Toldson, 2019; Jackson et al., 2005; Williams, 2012).

Medlock et al. (2019) find that in the U.S., racism in healthcare fits into three broad categories: 1) advancement of "unscientific, unethical, and unjust medical research and clinical practice (p. 341);" 2) upholding policies that have contributed to the disenfranchisement of Black people; 3) restraining the influence of Black physicians and obstruction of research to improve Black people's health. Data from the literature review support this summation (Anderson et al., 2009; Bailey et al., 2021; Brown Speights et al., 2017; Chambers et al., 2019; Cintron & Morrison, 2006; Cleeland et al., 1997; Goyal et al., 2015; Shavers et al., 2010; Smedley et al., 2003).

This next section uses these themes to guide the discussion of these findings' historical to contemporary manifestations. The literature review finds that the historical healthcare discussions regarding racism predominantly feature white male physicians' injustices. These examples of white supremacy and racial injustice allow us to view the foundation of racism in science and healthcare (and as such, I primarily discuss these examples). However, it is essential to remember that physicians, nurses, and social workers are also part of the context of healthcare in this period (Congress & Heyman, 2018; Heyman & White-Ryan, 2018; Jones, 1923; Knight, 2021; ONS, n.d.; Thornton, 1923; Webb, 1931; Woofter, 1923). Findings from the literature review provide egregious amounts of evidence of racism in healthcare.

Advancing Unscientific, Unethical, and Unjust Medical Research and Clinical Practice. In 1875, James Marion Sims, deemed the father of modern gynecology (Bailey et al., 2021), was elected president of the American Medical Association (AMA; Washington, 2006). Washington (2006) proclaims that such "respectability" obscures the "bloodied battlegrounds"

and agonized screams produced by Sims' torture and crude medical experimentation on enslaved Black females during the 1840s. Washington's (2006) research also finds that other physicians would run from the examination room, leaving the enslaved women to hold each other down in submission to the unanesthetized mutilations. Sims purchased enslaved Black women for this torture, yet the AMA awarded his *humanity* and *benevolence* in caring for and curing (white) women (Bailey, 2019; Owens, 2017; Villarosa, 2019; Washington, 2006).

Medical "torture" during slavery did not end with enslaved Black women. John Brown's (1854) memoir recounts the horrific torture by his enslaver, Dr. Thomas Hamilton, who would blister his skin to determine if "Black skin" was thicker than white skin. Brown (1854) was so tortured with hot embers that he could not work. Villarosa (2019) says that Hamilton was a member of the Medical Academy of Georgia and used enslaved people for medical experiments to gain “scientific” evidence that physiological differences existed between Black and white people's bodies. Physicians presented this type of research and scientific "fallacy finding" about Black people's genitalia, scull size, innate disease, pain insensitivity, and subhuman qualities in medical journals. They furthered racist ideas and policies (e.g., eugenics and laws against miscegenation; Bailey et al., 2021; Jackson et al., 2020; Villarosa, 2019; Washington, 2006; Willoughby, 2018).

Maintaining Policies That Contribute to the Disenfranchisement of Black People. During the 18th and 19th centuries in Europe and the U.S., Eurocentric racist "scientific" theories were developed to further colonialism and imperialism (Dumbrill & Yee, 2019; Medlock et al., 2019; Ricks et al., 2021; Willoughby, 2018). "What science produces is shaped by 'what we have in mind' (Dumbrill &Yee, 2019, p. 36)." Therefore, for colonization to flourish, white supremacy needed biologically based scientific theories and ideologies that supported the premise that

Others were inferior and should be exploited and subjugated to white hegemony (Ricks et al., 2021). Racist physicians went along with this notion, led the scientific torture, and profited from their services to white enslavers to treat the enslaved Black people on their plantations (Villarosa, 2019; Washington, 2006). The pseudoscience produced by physicians justified the savagery of white people against enslaved Black people and shielded the "well-respected" white persecutors. Samuel Cartwright was known for the psychiatric conditions he ascribed to Black people, like "drapetomania," which caused enslaved Black people to run away from confinement. His suggested cure was to keep Black people in submission by whipping them. Cartwright also used his power as a physician to justify slavery by characterizing Black people as lazy, having low intelligence, and insensitive to pain (Bailey et al., 2021; Medlock et al., 2019; Roberts, 2017; Willoughby, 2018). Schuster et al. (2011) found that Morel's 1857 Theory of Degeneration undergirded psychiatry for almost a century, was accepted across the medical field, and influenced white supremacist medical practices. These policies and procedures also found their way into medical school curricula and became the standard (The Sullivan Report, 2004; Willoughby, 2018). Medical journals described mental disorders supposedly affecting Black enslaved people based on pseudoscientific theories. During the early 20th century, these theories were responsible for eugenics and sterilizing those deemed mentally "unfit" to have children. Forced sterilizations also occurred in white communities for people considered mentally ill or intellectually developmentally delayed. However, forced sterilizations in Black communities resulted from a desire to stop "degeneracy" (Washington, 2006). Scientists generated theories ranging from genetic racial inferiority and mental degeneracy equating Blackness with criminality, madness, and "uncontrolled emotions" (Brandt, 1978; Jackson & Weidman, 2005; Medlock, 2019).

These racist practices and pseudoscience were foundational in healthcare and primarily responsible for the pejorative thinking and abusive treatment of Black people; they continued after legal enslavement ended in the U.S (Baker et al., 2008; Johnson, 2021; Obasogie et al., 2015). Healthcare practice with Black people morphed into familiar stories like the eugenics movements in which social workers were involved (Kennedy, 2008; Washington, 2006) and the infamous Tuskegee Syphilis experiments "which revealed more about the pathology of racism than the pathology of syphilis (Brandt, 1978; Frakt, 2020)." In addition, many doctors, particularly southern doctors, actively fought to sustain the beliefs of Black people's inferiority, to keep the system of slavery in place, and to limit acknowledgment of the contribution of Black people to healthcare (Baker et al., 2008; Baker et al., 2009). According to Brandt (1978), after emancipation, most white physicians said that "freedom" equated to "the mental, moral, and physical deterioration of the [B]lack population (p.21)."

Restraining the Influence of Black Physicians and Obstruction of Research to Improve Black People's Health. In addition to demonstrating the continuum of racism, the following section also highlights the counter-narratives and "relentless" agency of Black people. Despite the propaganda about white people's superior intelligence and fallacious science about Black people, during enslavement, Black people provided "healthcare" to their community and used their expertise in "healing" remedies for white people as well (Baker et al., 2008; Fett, 2002; Knight, 2021; Oncology Nursing Society [ONS], 2021). Black women served as hospital nurses to the sick (ONS, 2021; Owens, 2017). The preponderance of literature exploring the role of Black women in the antebellum period does not discuss the paradox of their role: the enslaved and subject of experiments, yet, in some cases, also expected to be nurses and assist in surgical and other treatment of patients (Library of Congress, n.d.; ONS, 2021; Owens, 2017). When

viewing this period from this angle, "we can better understand not only the science of race but also the contradictions inherent in slavery and medicine that allowed an allegedly inferior racial group to perform professional labor requiring substantial intellectual ability (Owens, p. 2)."

In addition to serving in plantation hospitals, some Black women took their skills to war and served as nurses in the American Civil War (National Institute of Health [NIH], n.d.). In 1863, Ann Bradford Stokes was enlisted in the U.S. Navy and paid regular wages to serve as a nurse on the USS Red Rover military vessel (History of American Women, n.d.; NIH, n.d.). Stokes was also among the first women to serve as a nurse in the Navy (NIH, n.d.). In 1878, Mary Eliza Mahoney became the first "formally" trained Black nurse (ONS, n.d.) at the New England Hospital for Women (a hospital run entirely by female physicians for women and children's health; Spring, 2017). Mahoney was one of 42 women who started the nursing school program and four who graduated (Spring, 2017). She left public nursing for private nursing because of racism and later co-founded the National Association of Colored Graduate Nurses (NACGN) to advocate against racism in nursing (Knight, 2017).

Black people also became physicians. The first Black doctor, David Peck, earned his medical degree in 1847 (Baker et al., 2008). Following him was John Van Surly DeGrasse, who joined the Massachusetts Medical Society in 1854 (Baker et al., 2008). The roadblocks set by mainstream nursing, social work, and medicine sought to deny entry and block these achievements and advancements for Black people (Frey et al., 2021; Washington et al., 2009).

The American Medical Association (AMA) from 1910 until 1968-waged a concerted campaign to diminish the success of Black physicians by denying them membership in the organization (Washington et al., 2009). Denying membership into the AMA was tantamount to ensuring that Black physicians could not practice as the AMA-credentialed hospitals and

physicians (Baker et al., 2008). Baker et al. (2008) confirm that medical society membership often meant the ability to make and receive patient referrals, admit patients to hospitals, become licensed, and receive continued training. The AMA's refusal (and subsequent exclusion from state and local medical organizations) to accept Black physicians meant that they practiced in isolation, received a smaller number of referrals, and felt the diminished source of income and educational opportunities (Baker et al. 2008; The Sullivan Report, 2004). Despite censure by the U.S. federal government and the courts and the support of some white physicians, the AMA used maneuvers involving disparate application of regulatory standards and jurisdictive machinations to bar Black physicians.

In 1895, several Black physicians founded the National Medical Association (NMA, n.d.; Profiles in Black Medicine, 2008) to provide support after continuous appeals by Black physicians and denial from the AMA for admission (Washington et al., 2009). In 1906, the AMA furthered the disenfranchisement of Black physicians in the U.S.; they listed them in their directory of physicians but in a separate section from white physicians with the "colored" designation attached to their names (Washington et al., 2009). Meanwhile, most white physicians deemed it a waste of healthcare resources to see Black patients but banned Black healthcare providers from practicing in their hospitals (The Sullivan Report, 2004). Emboldened by Flexnor's (1910) report, the AMA systemically targeted and closed Black medical schools in their racist attempt to circumvent Black physicians (Campbell et al., 2020).

The early 1900s saw the overt continuation of the devaluation of Black lives and Black healthcare by the lead medical establishment in the country—a de facto signal to white physicians, nurses, and social workers about the regard for Black lives. Flexner (1910) helped the AMA take over and centralize licensing, medical education and postgraduate training,

research, and the hospital system (Byrd, 2002, as quoted by The Sullivan Report, 2004). Flexner's (1910) report advised that Black physicians should be trained in cleanliness "rather than surgery" to protect white people from the spread of diseases from Black people (Hlavinka, 2020; Laws, 2021). Moreover, during the civil rights era, the AMA offered no support for ending segregation in U.S. hospitals or health policy issues, which negatively impacted Black people's healthcare (Washington et al., 2009). Five years later, Flexner (1915) would impact social work and set it on a path removed from social justice (NASW, 2020). Along with mainstream medicine, neither social work (Corley & Young, 2018; NASW, 2020; McMahon & Meares, 1992; Santiago & Ivey, 2020) nor nursing (Allen, 2006; Puzan, 2003) can claim that it stood against racism. Racism in healthcare morphs into different forms and debates of saliency throughout history, yet the enduring theme is that anti-Black racism keeps a stronghold on healthcare for Black people (Roberts, 1995; Roberts, 1997; Roberts, 2011; Roberts, 2017).

Contemporary Racism in Healthcare

Goldberg's (2011) determination that "words matter" brings us to an important finding in the literature----the significance of the lack of clarity around the terms used for conclusions about the system of health (access and outcomes): equality versus equity and disparity versus inequity.

Fundamental Terms: Health Inequities, Health Disparities, Equality, and Equity

Health inequities and health disparities, along with equality and equity, are frequently used interchangeably. Here, the author defines both health inequities and health disparities. However, to begin the discussion, the author parses the importance of equity versus equality as people often interchange both terms in the quest for racial and social justice.

Equality and Equity. Milken Institute (2020) explains, "Equality means each individual or group of people is given the same resources or opportunities. Equity recognizes that each

person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome (p. X)." A quest for racial and social justice in healthcare must consider the historical and contemporary oppression that impedes just outcomes. Farrow and Morrison (2019) note that social justice in healthcare for racialized people must move the conversation past a personal deficit focus and center equity. For a case in point, they offer an example of healthcare workers fostering community advocacy for safe physical spaces for activities to complement more traditional medical interventions. Therefore, my research and this discussion center equity and acknowledge that disrupting historical and systemic adversity and affording genuine opportunities for health equity may require different resources and nontraditional support.

Health Inequities and Health Disparities. Next, I offer definitions for health inequities and health disparities and underscore their variance in the literature. This discussion is vital as the literature is mixed in defining these terms and, as such, may blur the goals and dismantle the strategies to reach health equity for racialized people (Braveman, 2014; Meghani & Gallagher, 2008). Braveman (2014) states, "Health equity and health disparities are intertwined. Health equity means social justice in health (i.e., no one is denied the possibility to be healthy). Health disparities are the metric we use to measure progress toward achieving health equity (p. 3)." Braveman (2014) believes that ambiguity surrounding these terms and the lack of clear understanding of the definitions or consistency in the use of the definitions can impact the allocation of resources. For instance, some have used the term health disparity to discuss *all* health issues that occur differently between *any* group (e.g., health issues that disproportionately impact older people versus young people).

Meghani and Gallagher (2008) agree that there is an interdependence between health

disparities and health inequities. "Disparity implies a *difference* of some kind, whereas inequity implies *unfairness* and *injustice* (Meghan & Gallagher, 2008, p. 613)." However, they see health disparities and health inequities as "distinct concepts" in healthcare and assert that using them interchangeably could result in severe practice and policy implications that could have negative impacts. For instance, Meghani and Gallagher (2008) evaluated the documented disparities between pain analgesic administration for racialized people versus white people to determine what factors were at play. They found that although scientists noted the differences between the groups well, they reported it in a way that did not clarify if there was injustice perpetrated in the non-administration of pain medication to racialized people. They surmised that a "disparity is not undesirable in itself unless it results in some consequence understood as unfair or unjust. Unlike disparities, inequities are always undesirable and should be subject to serious moral criticism (Meghani & Gallagher, 2008, p. 615)." Therefore, health inequities are unnecessary and avoidable differences that are also considered unfair and unjust. Meghan and Gallagher (2008) highlight the importance of clarity when using these terms, as their misuse can impact the assessment of inequity at all levels in the healthcare field. In agreement, Braveman (2014) argues for a more apparent distinction by emphasizing that health equity is about justice for socially disadvantaged groups who systematically experience adverse social, economic, or political circumstances.

The matter is discussed as an ethical and human rights issue emphasizing the importance of health inequities (Braveman, 2014). Yamin (2009) argues that unequal economic, social, and human rights impact population health. Yamin (2009) further argues that undergirding the discussion of equality in health is understanding power and justice and the similarities and differences between people. Gruskin et al. (2007), using the HIV/AIDS epidemic as an example,

explain that transgressing individuals' rights often impacts their rights to health and well-being. They argue that healthcare workers must reduce and prevent these transgressions. Yamin's (2009) and Gruskin et al.'s (2007) discussions put health in the context of human rights. Their contextualization of health as a human rights issue leads us to Braveman et al.'s (2011) caution that broadening the health inequity discussion to abstracts like "ethics and human rights" could ultimately lead to decreased resources for the groups who have experienced the most significant disparities. However, they argue that the lack of progress to eliminate health inequities for racialized groups demonstrates that this is indeed a social justice issue. Braveman et al. (2011) conclude that healthcare must broaden the discussion. Raising it to the level of a moral and human rights issue underscores emphasis on health inequities for racialized people. Goldberg (2011) agrees that health inequities must be extended to the level of an "ethical valence" (i.e., a moral claim that ought to be taken up).

Access to Healthcare for Black people. The Office of Disease Prevention and Health Promotion (ODPHP; n.d.) state*s* that in the U.S., about "one in ten people do not have health insurance" (paragraph 1). In addition, other access issues include not having a primary physician for regular follow-up (including annual or sick screenings) and not living within a reasonable distance to health care services (ODPHP, n.d.). This becomes more than an inconvenience for rural Black families who do not have the financial means or the transportation to travel to medical appointments outside of their living area (Phelan & Link, 2015). It can mean life or death. Access can never be separated from the experiences with racism within healthcare settings (Phelan & Link, 2015). These factors often suggest that people will not access a physician until they are in an acute crisis. That access may be in the hospital emergency department, where they may be underdiagnosed and underserved due to their race (Meghan & Gallagher, 2008).

Outcomes in Healthcare for Black people. Scientific racism and the resulting disparate medical treatment of Black people that began over 200 years ago has an enduring legacy. Racism impacts healthcare delivery and access and continues to affect outcomes in the 21st century (Bailey et al., 2021; Baker et al., 2008, 2009; Came & Griffith, 2018; deShazo et al., 2014; Hardeman *et al.*, 2016a; Hardeman et al., 2020; McGhee, 2021; Poulain, n.d.; Roberts, 2011; Washington et al., 2009). The famous Heckler (1985) report and Smedley et al.'s (2003) *Unequal Treatment* highlighted this decades ago. The modern-day health inequities of treatment for pain for Black people (Booker et al., 2020; Goyal et al., 2020; Hoffman et al., 2016) and the mortality rate of Black women and infants during childbirth (CDC, 2021; Chambers et al., 2019; Leonard et al., 2019; Mehra et al., 2020; Ricks et al., 2020) directly connect to historical examples of racism within healthcare. The continuing themes in the health outcomes of Black people in the U.S. endure even when controlled for access and socioeconomic status.

Representation of Black Healthcare Providers. Washington (2006) states that Black people are still vulnerable in healthcare because "the racial homogeneity of American medical researchers lies at the very heart of the problem. (p. 30)." The Sullivan Report (2004) found that the health professions had not kept up with the demographics in the U.S. and estimated that this might be a factor in health inequities. Table 1 presents the demographics of Black people in nursing, medicine, and social work.

Table 1: Demographic Makeup of Healthcare Field in the U.S.

Healthcare Field	Demographic Makeup
Nursing (AACN, 2017)	Registered Nurses: 80.8% were white, and 6.2% were Black.
Physicians (AAMC, 2018)	Active physicians:56.2% were white, and 5.0% were Black.

Social Workers (NASW, 2020; ZIPPIA Career, n.d.)	Social workers: 65.8% were white, and 17-22% were Black.

Discrepancy in Professed Goals and Actions

The following section shares the professed goals of medicine, nursing, social work, and health-related science and problematizes their actions and the continued existence of racialized health inequities.

Medicine. The AMA (n.d.) states that "throughout history," it has "always followed its mission: to promote the art and science of medicine and the betterment of public health." AMA (n.d.) claims to be the physicians' powerful ally in patient care. Furthermore, the AMA (n.d.) states it represents doctors with a "unified voice," "removes obstacles for patient care," "confronts public health crises," and "tackles the biggest challenges in health care (paras. 1-2)."

These attestations are not held up by the decades of research demonstrating the unethical inequities that have not led to the "betterment of public health." Moreover, Baker et al. (2008) call out the medical profession for its role in racism and its harmful effects on Black people's health. Baker et al. (2009) remonstrate AMA for their refusal to admit Black people to the association and their interpretation and implementation of the Flexner (1910) report. Washington et al. (2009) call out the AMA for blocking research and healthcare among Black people by their lack of support, "variable credentialing," and procedural delays. Several physicians call for the medical profession to address racism in healthcare. Madara (2021), CEO of the AMA, states, "It is a difficult and potentially perilous exercise to examine our past through the lens of 21st century thinking (par. 1)." Madara (2021) does call for a change and work on equity and inclusion. However, Madera's (2021) statement is in the face of the abundance of literature that says the

past is directly related to the present suffering for Black people. Healthcare must examine the history to eradicate health inequities (Bailey et al., 2021; Smedley et al., 2003).

Nursing. The ANA (n.d.) states that nurses promote and advocate for patients' rights, health, and safety; nurses integrate principles of justice into nursing and health policy, protect human rights, and reduce health disparities. In contrast, Burnett et al. (2020) call for nursing to decolonize the curriculum. Rabelais & Walker (2020) say they are still asking the wrong questions, which will not lead to critical engagement of racism and whiteness (among other oppressions). They question the sincerity and non-performativity of nursing. Schroeder and DiAngelo (2010) assert the question in nursing is not, did racism happen? But how did racism present in this context?

Social Work. The NASW (n.d.) states that a value of the social work profession is social justice and that the ethical principle of challenging injustice is under this value. NASW states that social workers should work for social change on behalf of vulnerable and oppressed individuals and groups. Reisch (2017) says NASW issued a broad policy statement embracing racial equity, but the profession's "primary" goal is still expressed as the "individual well-being in a social context (p. 8)." Resich (2017) asserts that under the guise of "science," social work has brought to life "social Darwinist tendencies" to "essentialize group characteristics (p. 8)." NASW (2021) issued a public apology for racism in the institution of social work. NASW (2021) acknowledged years of segregated benefits; support of a self-proclaimed white supremacist, Albert Flexner; support and involvement in eugenics; blocking voting rights for Black people by social work suffragists; writing and implementing policies that left Black working people out; and bias by social work professionals that disproportionately negatively impact Black people's access and service in health care, mental health care, and social welfare services (including child

welfare). Amid calls for change (Abrams & Detlaff, 2020; Detlaff, 2020), they did not say how *action* or *change* would look.

Racism in Healthcare: Vexing Social Issue of the 21st Century

Impact of racism in healthcare

The impact of racism on the health of Black people occurs across the lifespan, with each day bringing a disproportionate possibility of morbidity and mortality. There are five race-related health inequities: earlier disease onset, differences across the continuum of illness, disparities in the vulnerability for some conditions, and health disparities that persist over time (Williams, 2012).

Adverse Effects on Health for Black People: Mental Health Mistreatment

Black Children. Calero et al. (2017) found that 50-80% of children in foster care live with mental health and behavioral health problems. "Black children are over-surveilled and over-policed by the child welfare system (Detlaff et al., 2020, p. 500)." NASW (2021) found that overdiagnosis and overrepresentation of Black children in the child welfare system occur because of social workers' bias. Social work has been called to examine the overrepresentation of Black children in child welfare (Kolivaski et al., 2014; Detlaff et al., 2020). Calero et al. (2017) found that children with disabilities are twice as likely to be suspended from school, which hinders their learning but also "correlates with higher chances of incarceration (p.7)." Calero et al. (2017) record social work as integral to the process of the overrepresentation of Black children in the foster-care-to-prison pipeline and the pathologizing of children's behaviors and systematic disregard for their health and well-being. The racism-based overidentification of Black and Brown children in child welfare services often sets up a negative trajectory in their lives (Adjie & Minka, 2019; Detlaff et al., 2020; NASW, 2021).

Lacasse and Gomory's (2003) research of social work graduate-level mental health psychopathology courses found that social work followed the medical model. They questioned if potential future social work mental health practitioners were "receiving the best scientific information, evaluation of evidence, and critical analysis currently available on mental health (p. 384)." The authors contrasted this approach of teaching mental health coursework within their sample of social work programs with examples of the policy critiques that the social work profession has lodged against policies such as the "War on Drugs" and "for-profit provision of human services." They found few similar critiques or problematization of the dominant "medical model" and view of mental health services. In essence, social work appeared to parrot dominant themes for psychiatric illnesses, becoming the "handmaidens" of the medical field (Lacasse & Gomory, 2003), which misses the mark of positioning practitioners as those able to interrogate systemic racism in healthcare. There have been calls for social work to address race, racism, and white supremacy in the field for decades (Shannon, 1970; Beck, 2019; Razack & Jeffery, 2002).

Black Adults. As noted earlier in the chapter, Morel equated being Black with "madness" and criminality. In the 1960s, the National Institute of Mental Health (NIMH) published studies indicating that Black people in the U.S. had a 65% higher rate of schizophrenia than white people; not surprisingly, in 1973, "studies" determined that Black people were more likely to receive schizophrenia diagnoses and less likely to receive diagnoses of depression or bipolar disorder. Metzl (2009) called this "protest psychosis" as psychiatrists during this era diagnosed this as a phenomenon produced by participation in the Civil Rights protests. The NIMH's declaration became a self-fulfilling prophecy. Recent literature indicates that Black people are still more likely to receive schizophrenia diagnoses and be treated with antipsychotic medications with debilitating side effects. They are still less likely to receive depression or

bipolar disorder diagnoses (Medloc et al., 2017; Metzl, 2009). For Black people, this stereotype correlates with the profiling and overrepresentation of Black people in the criminal legal system, beginning in childhood (Alexander, 2010). Medlock et al. (2017) indicated racial inequities in access, determination of symptom severity, diagnosis, and treatment of mental illness. Black men are four times more likely to be jailed than white people and, if they receive treatment, are more likely to receive treatment for their health symptoms in jail than in the community (Subramanian et al., 2015; Canada, 2021).

Impact of Racism in Healthcare on Society

Global Health Inequities. The health and well-being of Black people and people of color across the diaspora are indelibly tied to the path towards optimal health and well-being of Black people in the U.S. Global health inequities were a topic of concern long before COVID-19 (Deepak, 2019; Friel & Marmont, 2011). Racism and negative racial stereotypes against Black people and other racialized groups across continents, especially in the U.S., obscure and conceal white supremacy as a fundamental driver in inequities (Adelman, 2011; Feagin & Bennefield, 2014; Smedley et al., 2003). Jensen et al. (2021) point to the need for a global health equity agenda within and across countries to mitigate the impact of health inequities.

Health Inequity for Black People Harms All People. Healthcare (deemed an entitlement) in the U.S. often wages a zero-sum game. In other words, healthcare improvements for Black people equal healthcare losses for white people. McGhee (2021) says this belief is the lie of racism. Instead of either white people or Black people winning in racism, both lose. "White Americans increasingly represent a 'paradox' of privilege, access, and social rewards on the one hand and relatively poor health outcomes on the other (Metzl, 2019, p. 372)." Metzl (2019) reports that one of his white interviewees, who was dying of what would have been a curable

disease, said it was ok if he died because he did not want his taxpayer money used to cover healthcare costs for a "Mexican" or "welfare queen." Inequities in healthcare for Black people become part of a circular process reinforced by systemic racism, supporting systemic racism in society and hurting all people (McGhee, 2021; Metzl, 2019).

Interventions for Health Equity

Analysis of Systemic and Individual Interventions

Social Determinants of Health and Structural Determinants of Health

The social determinants of health (SDOH) are stability in the socioeconomic, environmental, and community context, education quality and access, and healthcare access and quality (Healthy People 2030, n.d.). SDOH contribute to health inequities and "affect a wide range of health and quality-of-life risks and outcomes (CDC, n.d.)." Monetz et al. (2021) claim that researchers have made a "health inequalities industry, which has become a career for the affluent (p. 295)," out of researching risk factors; instead, they call on researchers to look at structural components of inequities. Many researchers conclude that structural *racism* is the driver across the social and structural determinants of health; therefore, they find racism is the ultimate driver of health inequities (Bailey et al., 2021; Churchwell et al., 2020; Hardeman et al., 2016a, 2016b; Hardeman et al., 2018; Hardeman et al., 2020; Medlock et al., 2017; Medlock et al., 2019; Metzl & Hansen, 2014; Metzl & Roberts, 2014; Metzl, 2019; Williams et al., 2019). Interventions against structural racism are just beginning to evolve. 2020 saw a significant shift in the journals and medical literature, social work literature, and nursing literature, emphasizing the need to address structural racism in healthcare (Bailey et al., 2021; Elkassem & Murray-Lichtman, 2022; Murray-Lichtman et al., 2022a; Murray-Lichtman & Elkassem, 2021).

Cultural Competence Training

Cultural competence training is a strategy practiced in medicine, nursing, social work, and health-related science. It works to acquaint people with the essentialized characteristics of specific groups (Resich, 2017). Critics maintain that cultural competence training has done little to unseat racism or white supremacy (Abrams & Moio, 2009; Medlock et al., 2019; Metzl & Hansen, 2014).

Implicit Bias Training

Implicit bias training, like activities of awareness and reflection, does increase awareness of personal biases. Medical and nursing education began to use this strategy approximately a decade ago. Maina et al.'s (2017) systematic literature review found 37 studies, of which 31 demonstrated evidence of a pro-white and anti-Black result from the Implicit Association Test. Eight of these found no statistically significant evidence of impact on treatment or patient outcomes. While six showed an association between higher implicit bias and disparate treatment recommendations, pain treatment, and alliance and sensitivity toward the patient. Seven studies demonstrated that higher implicit bias associations resulted in inferior communication with the patients. However, "awareness" of implicit biases does little to impact racist structures, and more research is needed regarding moving from awareness to action (Fitzgerald et al., 2019; Gawronski, 2019; Marcelin et al., 2019).

Analysis of "Equity" Programs

Inclusion

Despite "inclusion" initiatives, research illustrates that while federal laws ended segregation de jure and de facto policies, "inclusion" policies often work together to undermine the success of Black students admitted to medicine, nursing, social work, and health-related science (Johnson, 2021; Hassouneh et al., 2014; Bowie et al., 2018; Briggs et al., 2018; Nieblas-

Bedolla et al., 2020; ONS, 2021). Often, programs create a space for "inclusion" but do little to dislodge the structural impediments or the actors invested in maintaining racism (Brown et al., 2019; Hassouneh, 2006; Holosko et al., 2018; Johnson, 2021; Zambrana et al., 2017). Recent legislation and lawsuits demonstrate a marked move away from even perfunctory inclusion policies and language (Killian, 2021).

Representation of Racialized Counter-Stories

The low numbers of Black faculty or others who identify with the challenges of being Black in a predominantly white space often feed into the stress of unfair assumptions and burdens Black faculty, practitioners, and students may face (Badwall, 2014; Bailey, 2019; Brown et al., 2019; ONS, 2021; Hollingsworth et al., 2018; Holosko et al., 2018; Scammell & Olumide, 2012; Valdez, 2017). Black bodies in these spaces are often taxed with unofficial and uncompensated support for Black students, more clinical duties, and called to sit on more committees as *the* Black representatives (Azhar & McCutcheon, 2021; Campbell, 2021; King-Jordan & Gil, 2021). ONS (2021) reports BIPOC faculty and students may experience a "lack of acknowledgment of their role or credentials; perpetuation of stereotypes; presumption of incompetence; retaliation; credit stolen by peers; disparities in wages; and outright denial of opportunities and advancement (par. 4)."

Absence of Racialized Providers

Racism has been the link between health inequities and the low representation of racialized people in the healthcare field (Campbell, 2021; deShazo, 2018). Faculty of color play an essential role in healthcare education to attract diverse students and address health inequities, yet they are underrepresented in healthcare (Argueza et al., 2021; Hassouneh et al., 2014). Black people continue to be underrepresented in leadership positions in nursing, medicine, and social

work (Banks et al., 2018; Campbell, 2021; Poole & Brownlee, 2020; Zambrana et al., 2017). The American College of Healthcare Executives (ACHE; 2020) notes, "Studies suggest diversity in healthcare leadership can enhance the quality of care, quality of life in the workplace, community relations and the ability to affect community health status (par. 6)." Recent research demonstrates the improved health of Black people when Black providers are present.

A Gap in the Literature Around white People Involved in Racial Justice Work

Overview of White Allyship in Racial Justice and Equity Work

This next section gives an overview that highlights some examples of white people who have worked against their interest in whiteness to make a difference in the lives of Black people and other people of color. Bailey (1998) explains that it is a "troublesome puzzle: the problem of how to describe and understand the location of those who belong to dominant groups yet resist the usual assumptions and orientations of those groups (p. 284)."

The "discovery" of whiteness is a modern anomaly. Yet, an inescapable one—even people who do not raise it in conversation are impacted by it (Du Bois, 1903/1986). So then, Bailey's categorization of people into "three archetypes of knowers: the disembodied spectator, the outsider within, and the traitor (p. 284)" guides my discussion. Bailey (1998) describes white people as either "privilege evasive" or "privilege cognizant." Race traitors are privilege cognizant and "occupy the center but [their]… way of seeing (at least by insider standards) is off-center...[they] destabilize their insider status by challenging and resisting the usual assumptions held by most white people (p. 288)." They interrogate white complicity (Applebaum, 2010, 2015), are actively anti-racist, and have rejected the notion that their white privilege and white hegemony are "merited." For more understanding, Segrest (1994), who called herself a race traitor, said, "It's not my people, it's the idea of race I am betraying (p.32)." These categories may

be helpful for my investigation into the experiences of white healthcare providers.

Historical and Contemporary Research and Scholarship as Racial Justice Work

The literature review offers suggestions about how white people might engage with white people, their whiteness, and Black (or other racialized) people. This may inform white healthcare workers' orientation toward racial justice work. Each scholar I reviewed dedicated a significant part of their work to racial justice in the form of epistemic disobedience. Frankenberg's (1993) qualitative study of 30 white women analyzed their racial social geography (i.e., their physical and material locations pertaining to race); her findings are relevant for the contemporary continuum that might situate white healthcare providers. Frankenberg (1993) found no predictors in the women's childhood experiences linked to how the women would react or participate in anti-racism or racism as adults. In agreement with Frankenberg (1993), Hagerman's (2018) longitudinal study of white children in the U.S. finds a similar conclusion. Frankenberg (1993) describes socialization by some of the women's mothers and families that either blatantly called out boundaries between white people and Others (mainly Black people) in the form of warnings of danger and racist discourse. She also describes socialization that would allow the white women to "see" the oppression of Black people and yet maintain a sense of their race (as unmarked), position (as hierarchal), and privilege (as neutral). Frankenberg (1993) describes the racist discourse about Black people as "essentialist racism," which kept Black people (or people of color) as always marked inferior, different, less civilized, subhuman, and animalistic. Frankenberg (1993) connects the racist discourse with the stoked fear of Black men throughout history as dangerous and sexual predators seeking white women.

McRae (2018), Frankenberg (1993), and Jones-Rogers (2019) found that the system of racism embedded in the fabric of every interaction in the U.S. socialized and shaped white

women. The reality of white women's role in white supremacy, raised by each of these scholars, is contrasted with the concept of the "innocence" and "goodness" through self- and societal-perceptions (Frankenberg, 1993; Jones-Rogers, 2019; McRae, 2018; Newman, 1999). Applebaum's (2010, 2015) discussion of white people's ongoing complicity in white supremacy overlays Frankenberg's (1993) charge that white people must constantly examine themselves and situations that they may not have held up to the interrogation of racism.

The Experiences of White People Who Work for Racial Justice

Motivation for Involvement in Racial Equity Work

Selvanathan et al.'s (2017) study used quantitative analysis of 821 respondents to determine that positive interpersonal contact with Black people fosters empathy and anger at injustice towards Black people, inspiring a greater willingness for collective action on behalf of the issues impacting Black people. Perry and Shotwell (2009) agree, adding that in addition to an understanding of the Other, anti-racism practitioners also need to understand themselves in relation to understanding race, racism, and anti-racism practice. Fingerhut and Hardy's (2020) study surveyed 416 self-identified white allies involved in racial justice. They found that a perception of social support and a sense of personal satisfaction with racial justice work positively influenced their participation. Uluğ and Tropp (2021), reporting results from three studies, find that white people witnessing racial injustice enhances awareness of their privilege and shapes their inclination for collective racial justice action. Case (2012) finds that some women in their study see their intersecting identities and privilege as components of why they pursue anti-racism work. However, the theme of "social norms (i.e., not causing trouble) also emerged with their self-described allyship and anti-racist work and would interfere with their self-appointed goal of allyship and anti-racism. They found that they could overcome this to

some degree by talking with others with racist views one-on-one and by supporting/gaining the support of other anti-racist workers. Bussey’s (2021) study with social workers who identified as anti-racist found that childhood experiences, including values about race in the family and exposure to racialized people, led to the embrace of anti-racism beliefs. Finally, Warren (2010) offers a qualitative counterpart similar to Selvanathan et al.'s (2017) study. Warren's (2010) study of 50 white people, including educators, community organizers, and legal advocates actively engaged in racial justice work, finds that racial justice activism starts with a moral impetus and includes building relationships with people of color; the relationships change white activists' views on racism and foster deeper caring about Black people's struggles with racism.

Experiences and Counter-Stories

Kivel (2017), an anti-racist white male activist, states that racism influences everything, and the anti-racist fight is critical. Moore et al. (2015) edited the personal stories of 14 self-described white racial justice workers who call themselves “everyday white people” to stress their racial justice work as something every white person should commit to. Their personal stories of anti-racism are written for other white people and weave together the “cognitive dissonance and denial” they experienced as part of their journey of racial justice work (Gorski, 2015, p. x). Thompson et al. (2003) began their quest for anti-racism by unearthing the counter-narratives of white men involved in racial justice work. They included 35 white men in their historical analysis but omitted hundreds of other stories. The men they highlighted were surrounded by people of color who were also fighting for racial justice; their narratives stand as calls for anti-racist work by contemporary white men. Feagin and O'Brien's (2003) study of white male executives found that most of the men express "sincere fictions" and color-blind notions about whiteness, but behind "the façade," they were cognizant that they held privileged

"socioracial" positions. A minority of white men in the study were actively anti-racist and worked to make anti-racist changes in society by becoming involved in racial justice work. These men believed that everyone would be better off without racism. These counter-narratives and those that follow are often left out of the white supremacist narrative of history.

The following counter-narratives describe individuals whose involvement in racial justice activities put their lives in danger, and some lost their lives for their racial justice work. From John Brown to the Freedom Riders, their stories and others like them are often left out of historical narratives. However, their efforts gave hope to countless Black people fighting for their lives and well-being.

John Brown (1800-1859), a white abolitionist, joined those white people who literally gave their lives in the fight to unseat racism and white supremacy (Du Bois, 2007; Finkelman, 2011). "For [white] Southerners, Brown was the embodiment of their fear—a white man willing to die to end slavery. For many Northerners [and Black people], he was the prophet of righteousness (Finkelman, 2011, para. 6)." Despite immense opposition, Brown's father was responsible for one of the U.S.' first integrated colleges (Finkelman, 2011).

Brown fought and died on behalf of his belief in the humanity of Black people. His work included speeches against the inhumanity of the enslavement of Black people, raids to undermine political factions favoring depravity towards Black people, and funding, transporting, and hiding Black people who ran from enslavement. He championed the rights of Black people using the professed ethical and civil standards whereby white people were given freedom under the constitution of the U. S. (Du Bois, 2007; Finkelman, 2011). John Brown fought to end the system of slavery within the U.S. John Brown's fight was based on his religious beliefs of justice to promote the lives of Black people as worth saving and ultimately worth dying for. While

resting in his religious convictions, his beliefs belied the religious beliefs of most white people of his day and were deemed radical. John Brown's actions were not just "for" Black people. "He worked with them; and he was a companion of their daily life, … and felt, as few white Americans have felt, the bitter tragedy of their lot (Du Bois, 2007, p. 65)."

Other white activists subverted racism and white supremacy by their undercover work to fight white supremacy. Mab Segrest (1994/2019), impacted by her family's involvement in white supremacy, went undercover in the Southern U.S. state of North Carolina to unseat white supremacist terrorists. John Howard Griffin (1960) assumed a Black identity and traveled to the South to understand the claims of racism being made by Black people and help stage the battle against racism. Similarly, Grace Halsell (1999), after hearing about the hardship of traveling in the South as a Black person, darkened her skin and traveled in the North and South as a Black woman. While "Black face," darkening of the skin to appear Black, in an effort to ridicule or appropriate Blackness, is white supremacist and has a history in the U.S., Griffin and Halsell's actions were to bear witness and give testament to the degradation and injustice of racism and white supremacy during a period that was besieged by Jim Crow segregationist laws and deadly practices. Both Griffin and Halsell would have likely been killed if they had been discovered. Their bearing witness was for other *white* people who were able to excuse, look away from, or otherwise ignore the deadly plight of Black people during this period.

Finally, the "unlikely dissenters" and "freedom riders" are two groups from the Civil Rights era, noted as working together for their anti-racism efforts (Stefani, 2015). Unlikely dissenters were intergenerational southern white women determined to fight for racial justice in the U.S. South (Stefani, 2015). The Freedom Riders were an interracial group of white and Black people who defied white supremacy and racism in the South. Many Freedom Riders were white

college students who joined Black college students in the civil rights battles of the 1960s. Several freedom riders lost their lives participating in integrated bus rides and other anti-racist actions for integration (Arsenault, 2007).

Racial Justice Work of White Healthcare Providers

While all the shared narratives of anti-racism work were in the investment of the well-being and life (or death) situations of Black people, the following stories share the counter-narratives of people actively involved in anti-racism efforts in healthcare. Their racial justice efforts assisted with the delivery of healthcare to Black people in situations where such services were non-existent. In both cases, they followed the leadership of Black people and were determined to get healthcare to people living in dire circumstances.

Dr. Frederic Wertham sets an example in the formation of a healthcare clinic and the denunciation of racist treatment of Black people in mental healthcare (Doyle, 2009a; Doyle, 2009b; Wright-Mendoza, 2019). Before 1946, Wertham, a white doctor, approached New York City white philanthropists and hospitals to secure funds to establish a clinic to treat Black people (Doyle, 2009a; Doyle, 2009b; Mendes, 2015; Wright-Mendoza, 2019). Wertham made the case that the disproportionate number of Black youths "legally" charged as "juvenile delinquents" was due to the racism that Black people faced. He denounced the pseudoscience of "criminality and degeneracy of Black people" that was the mainstay of psychiatry; the philanthropists denied Wertham's funding requests (Mendes, 2015; Wright-Mendoza, 2019). Richard Wright and Ralph Ellison conferred with Wertham about a clinic in Harlem; healthcare within the Black community had been a significant push from the Black Panther Party (Nelson, 2011). Ellison and Wright secured donations and a space for the clinic (Mendes, 2015; Reibman, 2001). Wertham recruited volunteers and led an interracial coalition of physicians, nurses, and social welfare

workers to treat the mental health needs of Black people in Harlem's Lafargue clinic (Doyle, 2009a; Doyle, 2009b; Wright-Mendoza, 2019). Wertham's contribution to racial justice sets the stage for understanding the harm caused by under-resourcing healthcare and systemic racism in Black communities.

Finally, like Wertham's example of a multi-disciplinary interracial team, the Medical Committee for Human Rights (MCHR) also sought racial justice in healthcare. Dittmer (2009 and Wells (2004) describe that the MCHR began as an interracial group of medical students and doctors who met for discussions during the Civil Rights era. The MCHR became a multi-disciplinary coalition of Black and white physicians, social workers, psychiatrists, nurses, and sociologists led by Black doctors. Their driving force was responding to the healthcare needs within the Black community. At the time, the most pressing need was to address the casualties from the brutal attacks of racism and white supremacy aimed at those participating in the fight for civil rights in the South. The MCHR traveled in groups to the South, identifying themselves as medical personnel to care for the wounded. This meant MCHR members often participated in marches and were present at demonstrations to care for those attacked. While this put the MCHR on the scene to save the lives of the wounded, it also placed them in danger, and some were arrested and otherwise mistreated because of their racial justice work. The work of the MCHR continued after the Civil Rights era, taking on other healthcare crises within the Black community. The MCHR provided a model for racial justice work and the fight against health inequities (Dittmer, 2009).

Chapter Three Summary

Chapter Three offered an overview of health inequities among Black people and the institutionalization of racism and white supremacy in healthcare. The discussion highlighted the

discrepancies in the stated mission of medicine, nursing, social work, and health-related science and the interventions to address health inequities. Next, the chapter discussed the key theme of historical and contemporary racism and white supremacy manifested within the professions. In conclusion, the chapter presents counter-narratives of white people involved in racial justice work broadly and then specifically the counter-stories of white healthcare providers who worked for racial justice in healthcare.

I am what time, circumstance, history, have made of me, certainly, but I am also much more than that. So are we all.

—Baldwin, 1984, p. 151

Chapter Four: Methodology and Research Design

This chapter discusses my substantive area of research, white healthcare providers involved in racial justice work, my motivation for the research, and my journey to qualitative inquiry, specifically Interpretative Phenomenological Analysis (IPA), as the vehicle for my research. The researcher explores her positionality and explain IPA's suitability for her substantive area, including my research topic and theoretical framework. Next, she provides an overview of IPA, with an in-depth description of the research design, sample recruitment, data collection, and analysis methods applied to my research.

Finding a Research Design: Health Equity and Racialized People

Strega and Brown (2015) ask questions that researchers must consider in order to move research and scholarship to a more socially just practice. "Whose story will our research tell, why, to whom, and with what interpretations (p. 4)?" The research beneficiaries and the knowledge produced from the research are directly related to the methodology used for the analysis. This is salient for research about health inequities and racial justice work. Who benefits from framing "health inequities" as the community's fault (Feagin & Bennefield, 2014)?

Social Location and Positionality

The researcher situates herself in this work as a critical theorist and, as such, approaches research understanding that she filters her observation of the "objective" reality of oppression through her values and "knowledge," and her research is value-laden. The research goal is to transparently embrace these values and incorporate the ideology to produce emancipation

through the research (Creswell & Poth, 2017; Morris, 2006). Though the researcher has power and privilege as an academic and through other intersecting identities, living within a racialized Black body in a racist society has robbed her of the ability to enter this work neutrally and without bias. Critical researchers begin with their worldview of oppression, guiding their research (Creswell & Poth, 2017). Lorde (1984/2007) asks, "What are the particular details within each of our lives that can be scrutinized and altered to help bring about change (Lorde 1984/2007), p. 122)?" As a racialized scholar and critical researcher, the focus on the extreme health inequities for Black people implicates the researcher and her philosophical assumptions (Roberts, 2013). Her axiology is that her racial and social justice values must inform her work. Her ontology is that racism is endemic and systematizes white supremacy in health care and a social system that blames the "victim" for their suffering. Her epistemology deems that research must critically examine social situations to bring emancipation and transformative change.

As a Black woman watching the virus attack Black and Brown communities and adjusting to the absence of loved ones who died due to COVID-19, the researcher's desire to eradicate health inequities has never seemed more urgent. The upsurge of white nationalism and white racist groups created a double impetus for the research. The researcher borrows from Lorde (1984/2007) and other anti-racism Black feminists and countless "race workers" before her, understanding that because of her social location, her investment in race work is personal and political.

Black social welfare pioneers in the United States named it race work (Carlton-LaNey, 1999). They felt compelled to do race work for the welfare of the Black community (Carlton-LaNey, 1999, 2001; Este et al., 2018; Hall, 1954). They found a way of dealing with their present context- a world of suffering for Black people, with attacks and harm to our bodies that,

in and of themselves, are continuous attacks on our minds (Lerner, 1972). There is no neutral or bias-free position, the researcher's interest in racial justice in healthcare stems from her social location and experiences as a Black person in a white supremacist society. The biopolitical space she embodies situates her with race workers of past generations since saving lives in the Black community inextricably ties to her Black body.

Research and the Academy: A Qualitative Versus Quantitative Debate

The consideration of the consequential nature of research that amplifies the voices of white racial justice workers and yet the (un)acceptability and marginalization of this worldview by institutionalized white supremacy overlayed my reviews of a research methodology (Carroll, 2004; Cypress, 2017; Kovach, 2009). "The ability to define humanity, to determine significance or importance, and to determine the future has an important impact on research and scholarship (Ladson-Billings, 2003, p.10)." This tension exists within academic spaces between the acceptance and legitimization of quantitative research (Kovach, 2009; Mignolo, 2009; Scarnato, n.d.; Torrance, 2018) and the objections to qualitative research despite its growth in popularity and calls for counter systems of knowledge production (Carroll, 2004; Cypress, 2017). Ladson-Billings (2003) challenges the institutionalized "knowers" who discount "nonconforming" knowledge production such as qualitative research and embrace quantitative knowledge production because of the perceived scientific rigor and use of "measurement" and "numbers" for inquiry (Cypress, 2017; Scarnato, n. d.).

Feagin (2013) agrees with Ladson-Billings, noting that the tension is reified through the connections between funders and accepted "knowledge-production," often entrenching the status quo. Accepted knowledge production seldom includes topics like the impact of institutionalized white supremacy and racism or interventions to disrupt their systemic manifestations, creating a

point of dissonance for the researcher. How do researchers participate in meaningful research that fills a gap in critical knowledge and empowers those involved while conforming to the normative standards of the academy and funders? For this researcher, this included the unpopularity and precariousness of posing questions with qualitative inquiries that seek to raise counter-narratives to social systems versus quantitative investigations that might measure social indices and circumstances without the voices that explain the social system of the researched. While many scholars have begun to implicate themselves in the systems they research, a majority do not, and research or scholarship around systems issues, such as the implications of the impact of racism and white supremacy on health inequities until recently, have not been widely published or funded (McFarling, 2021).

Philosophical Assumptions Underlying the Research

As the researcher considered different methods, she found that each developed from broad philosophical assumptions about the nature of reality, the nature of knowledge, and the role of values attached to the research (Creswell, 2007). This became the basis of the decision about the particular methodology for this research. The methodology had to be congruent with the critical voice that the researcher brings to the study and her belief in the objective reality of racism.

Quantitative inquiry was birthed in the positivist paradigm and embraced research as objective and value-neutral (Denzin & Lincoln, 2018; Leavy, 2014; Scarnato, n.d.; Osborne, 1994; Torrance, 2018; Spencer et al., 2014). The adage that "knowledge is power" becomes more remarkable when contextualized within a system of power that shapes knowledge production and the accepted ways of knowing and being while devaluing other methods of inquiry (Feagin, 2004; 2013; Mignolo, 2009). Foucault (2010) explains that the "will to truth, like other systems

of exclusion, relies on institutional support (p. 447)." This researcher believes in the objective truth of racism and oppression; however, this approach to knowledge production as value-neutral often may fail to situate the data within the sociopolitical context from which it emerges or acknowledges the values that drive researchers to ask particular questions (Kirby &McKenna, 2004). In turn, this may reinforce the dominant narrative and minimize or not give voice to the experiences of the researched (Carroll, 2004; Feagin, 2013; Foucault, 2010; Kirby & McKenna, 2004; Kovach, 2009; Ladson-Billings, 2003; Torrance, 2018). Therefore, quantitative inquiry might provide a powerful adjunct to measure the prevalence of a phenomenon, and it may be a more "accepted" method. However, quantitative research does not fit with the researcher's philosophical assumptions or the nature of the research inquiry.

Many social science researchers embrace qualitative research to unveil counter-stories and experiences that emancipate and transform hegemonic and oppressive systems (Buggs et al., 2020; Denzin & Lincoln, 2018; Feagin, 2013). Although, qualitative research is not a monolithic methodology that always engages its sociopolitical context (Brinkman et al., 2014; Creswell, 2007; Larkin et al., 2006). Qualitative research is a canopy for many different methodologies for inquiry (Creswell & Poth, 2017; Denzin & Lincoln, 2018).

As with quantitative research, qualitative approaches are also informed by philosophical assumptions and specific interpretative or theoretical frameworks (Creswell & Poth, 2017; Denzin & Lincoln, 2018). Qualitative research is often used to explore, describe, or explain social phenomena and the meanings that people attribute to the phenomenon (Denzin & Lincoln, 2018; Leavy, 2017). Over its history, qualitative approaches have moved inquiry from the positivist paradigm of objective, value-neutral "truth" to embrace the ontology and epistemology of indigenous, critical, feminist, and decolonizing approaches to research (Carroll, 2004; Denzin

& Lincoln, 2017; Kirby & McKenna, 2004; Kovach, 2009; Leavy, 2014; Madison, 2020). Qualitative research allows social scientists to seek answers about lived experiences. It can be an avenue for research to focus on relevant issues to local communities and issues that speak to power and oppression (Denzin & Lincoln, 2018; Leavy, 2017).

Conceptual Framework Shaping the Research

As discussed earlier, researchers approach the research with certain philosophical assumptions (Cypress, 2017). The researcher's decision to use qualitative research locates her positionality to the study, her ontological and epistemological beliefs, and her disagreement with positivist approaches to knowledge production. Now, the discussion ties in the critical theories and philosophical assumptions that led to the research question and the conceptualization of the inquiry. Cypress (2017) describes theories as an "organized and systematic set of interrelated statements that specify the nature of relationships between 2 (sic) or more variables with the purpose of understanding a problem or nature of things" (p. 211). Cypress (2017) further describes theories as a structuring element for a research study that can inform the philosophical commitments of the research. These philosophical commitments include the researcher's ontology (belief in the nature of reality), epistemology (how does the researcher know and what does the researcher know), and axiology (the role of values in the research; Creswell, 2007; Creswell & Poth, 2017). As a critical theorist and researcher, the research question became a tool to move the conversation from individualizing health inequities among Black people to achieving health equity through racial justice work.

Therefore, the research aims not to measure racial justice work but to allow the counter-story of white healthcare workers involved in racial justice work to emerge. Qualitative inquiry enables the researcher to understand the sociopolitical context in which human beings and their

accompanying social issues are situated. The research goal is to shed light on human experiences and interpret those experiences through the context of the social problems and the social environment of the experiences (Creswell & Poth, 2017).

Choosing the Appropriate Qualitative Method

As mentioned above, qualitative research approaches are not monolithic. Many approaches have varying criteria for theoretical frameworks, data collection, and analysis methods (Creswell, 2007; Creswell & Poth, 2017; Rubin & Babbie, 2007). For the research to produce emancipatory and transformative change, the methodology must allow for the critical examination of the racial justice work of white healthcare providers. IPA allows the iterative analysis and the researcher's reflexive process (Madison, 2020). Phenomenology, specifically IPA, is a qualitative methodology that "contributes to deeper understanding of lived experiences by exposing taken-for-granted assumptions about these ways of knowing" (Starks & Trinidad, 2007, p. 1373). IPA provides a medium to obtain rich narrative details of the phenomenon. Most importantly, IPA offers the opportunity to critically examine white healthcare providers' "embodied" experiences of racial justice work within the sociopolitical context of white supremacy and racism (Giwa, 2018; Osborne, 1994; Pascal, 2010).

An Overview of the History of Phenomenology and a Description of IPA

The following section provides an overview of IPA, beginning with the history of Phenomenology. Following the historical overview, a description of IPA grounds the discussion. Finally, the researcher discusses IPA as the methodology for the research and the methods utilized for the research.

History of Phenomenology

Phenomenology is considered both a philosophy and a research method (Creswell & Poth, 2017; Cypress, 2017; Moustakas, 1994; Newberry, 2012; Tuohy et al., 2013; Wertz et al., 2011; Yancy, 2014). Phenomenology as a research method has been used across many disciplines, including healthcare and social work (Anderson-Nathe, 2008; Cypress, 2017; Larkin et al., 2006; Newberry, 2012; Neubauer, 2019; Pascal, 2010; Tuohy et al., 2013; Wertz et al., 201; Wilding & Whiteford, 2005). Phenomenology seeks to examine how individuals understand their lived experiences. The phenomenologist seeks the common meaning or essence for several individuals of their lived experience of a concept or a phenomenon (Anderson-Nathe, 2008; Crypress, 2017; Finlay, 2009; Moustakas, 1994; Neubauer, 2019; Smith & Osborn, 2015; Starks & Trinidad, 2007; Zahavi, 2019a). Phenomenology as a research methodology can be traced to Edmund Husserl, its founder in the early 20th century. From there, Moustakas, Heidegger, Gadamer, Satre, Merleau-Ponty, and many others broadened the work of Husserl (Creswell & Poth, 2017; Cronin & Lowes, 2015; Disprose & Reynolds, 2014; Neubauer, 2019; Newberry, 2012; Smith et al., 2009). Husserl wanted to find out how a person knew about their experience and identify its essential features. These features would then transcend the individual to a common understanding of the phenomenon (Smith et al., 2009).

The Emergence of Two Branches of Phenomenology

A debate emerged among the early founders of phenomenology, Husserl and his student Heidegger. The debate was over Husserl's insistence that the role of the researcher was to separate themselves and accompanying values to reduce the researcher's influence and allow the participant's detailed experience to stand alone. Husserl believed that the essence of the experience would emerge from this rich description. Husserl's view of phenomenology moved from the positivist belief in an objective "Truth" to the subjective embrace of many "truths" that

could be highlighted in the rich description of an individual's subjective experience of a phenomenon. Yet, Husserl maintained the idea of research being value-free (Creswell & Poth, 2017; Cypress, 2017; Disprose & Reynolds, 2014; Newberry, 2012; Smith et al., 2009; Smith & Osborne, 2015; Tuohy et al., 2013; Zahavi, 2019a). Husserl's view would be later developed into a methodology by Moustakas (Moerer-Urdahl & Creswell, 2004; Moustakas, 1994).

While Husserl did not emphasize the context of that description, Heidegger saw the researcher's role and the research's goal differently. Heidegger believed that the researcher should seek a rich description; however, Heidegger believed this description must then be interpreted by the researcher (Creswell & Poth, 2017; Cypress, 2017; Disprose & Reynolds, 2014; Newberry, 2012, Smith et al., 2009; Smith & Osborne, 2015; Tuohy et al., 2013; Zahavi, 2019a). Of the phenomenological traditions that emerged, Husserl and Moustakas are credited with transcendental (descriptive) phenomenology while Heidegger, Gadamer, and van Manen are credited with hermeneutical interpretive phenomenology (Creswell, 2007; Creswell & Poth, 2017; Cypress, 2017; Disprose & Reynolds, 2014; Moerer-Urdahl & Creswell, 2004; Moustakas, 1994; Newberry, 2012, Smith et al., 2009; Smith & Osborne, 2015).

As alluded to earlier, Heidegger, and later expanded by Gadamer, argued that phenomenology had to go beyond description; they posited that to get at the essence of the experience, the phenomenologist must understand the hermeneutical meaning or interpretation given by the participant to the experience (Anderson & Nathe, 2008; Newberry, 2012; Dreyfus & Wrathall, 2005). Heidegger's take on Hermeneutical Interpretative Phenomenology posited that understanding "being in the world" involves understanding oneself in relation to the social world. Through this relationship with the social world, the essence of the experience is interpreted (Dreyfus & Wrathall, 2005). Heidegger rejected the notion that the researcher could suspend pre-

judgments, insisting that pre-judgments are brought to each encounter. Heidegger embraced the pre-judgments as part of the "hermeneutic circle," explaining that the researcher makes sense of things by weighing each new piece of knowledge with what is already known. This circular process of knowledge production relies on the researcher's preconceptions and, with those, creates new meaning and interpretation of that meaning (Dreyfus & Wrathall, 2005; Newberry, 2012; Smith et al., 2009). Heidegger made significant contributions to hermeneutical interpretive phenomenology. Most striking is Heidegger's take on phenomenology as a hermeneutical and interpretive process immersed in the sense of "being in the world," thereby including the sociohistorical context of the participant's experience (Newberry, 2012). Similarly, Merleau-Ponty expanded phenomenology to a transformative tool when used to inform accounts of human existence and the politics involved in that existence (Disprose & Reynolds, 2014).

The significant similarity between the two orientations is that the researcher engages a phenomenon that a shared cultural group experiences and uses an idiographic approach to move from the essence of the individual experience to the common essence of the experience (Cypress, 2017; Miller & Minton, 2016). The differences include the researcher "bracketing" themselves (suspending all judgments) and describing the phenomenon in transcendental phenomenology. In contrast, in hermeneutic interpretive phenomenology, the researcher takes the "living phenomenon" and interprets it within the socio-political context of life (incorporating both researcher and participant subjectivities; Creswell, 2007; Creswell & Poth, 2017; Cypress, 2017; Newberry, 2012; Pascal, 2010; Zahavi, 2019a).

Salient Takeaways from Phenomenology for the Research Topic

The study of phenomenology yielded many benefits for the research. The first of these benefits came from Husserl's thoughts about coming to know the "Other's" subjective being as an opportunity for them to cease to be the "Other." The researcher was transparent in seeking to elevate white healthcare providers fighting racial injustice. As such, the researcher embraces Husserl's idea that through a detailed description of white healthcare workers' racial justice work, she might bring skeptics into the space where they understand the essence of this experience. The coming to know the experiences of "white" people who are working against the grain and possibly not in the interest of their whiteness works against the perpetuation of silencing of the racism that exists within healthcare.

Most notably, Heidegger's take on phenomenology as a hermeneutical and interpretive process immersed in the sense of "being in the world" resonated with my worldview. What is most astounding, and that the researcher is still interrogating is how Heidegger was able to capture and make sense of this lens-- the importance of the social context-- while also participating in and embracing racist and xenophobic views as a member of the Nazi party (Newberry, 2012; Dreyfus & Wrathall, 2005). The researcher grapples with the role that Nazism played in Heidegger's orientation to the methodology. She also recognizes that past scholars such as W.E.B. Du Bois (1899) took the accepted methodologies and used that language to contest oppressive social circumstances and racism (Morris, 2015). Therefore, while Heidegger's orientation may have been firmly planted in white supremacy, as scholars before this researcher, she will use this lens to interrogate and problematize racism and white supremacy in the social context. In addition to the contributions referenced above, Merleau-Ponty and Gadamer expanded the researcher's vision of the benefits of phenomenology for the present research.

Merleau-Ponty's views were similar to Heidegger's, expanding the idea of phenomenology to an emancipatory tool that linked existence and the essence of one's being to the historical, social, and political world. Merleau-Ponty's expansion of phenomenology allows the researcher to consider the subjective "truths" as "Truth" when those experiences are also perceivable in and of themselves in the sociopolitical context of the world (Disprose & Reynolds, 2014). Gadamer, a student of both Husserl and Heidegger, also expanded the discussion with his take on the reciprocity between the participant and the researcher. In other words, in direct contradiction to Husserl's "objective" stance, Gadamer expanded Heidegger's vision. Gadamer felt knowledge is created within the dialogue, with both the researcher and the participant contributing to the meaning of the new knowledge (Newberry, 2012). Most importantly for this research, Gadamer believed that a researcher's ability to make conclusions and interpret a phenomenon is mediated through pre-judgments or biases (Cypress, 2017; Newberry, 2012). Gadamer argued that this brings the researcher's attention to the phenomenon and, in this case, guides the inquiry into the white healthcare workers' racial justice work.

From these two approaches, phenomenology grew to produce variants like Interpretative Phenomenological Analysis (IPA). The discussion shared the points from phenomenology which are salient to this research. In addition, IPA brings the idiographic commitment to the rich descriptive details from phenomenology and the interpretive collaborative meaning-making process to the research project (Smith & Osborne, 2015). In the next section, the discussion covers IPA, which originated with John Smith (Miller & Minton, 2016; Smith et al., 2009; Smith & Osborne, 2015) and follows the Heideggerian concept of the researcher as part of the research.

IPA: The Experience of the Racial Justice Work and the Consistency of Critical Theory

For the final section of this chapter, the discussion focuses on IPA as it applies to the research topic and describes IPA and its ontology and epistemology. The discussion will also explore the congruency between IPA, CRT, and CWS. "Grounded in principles of phenomenology, hermeneutics, and idiography, researchers using IPA aim to explore individuals' meaning-making related to certain significant experiences" (Pietkiewicz & Smith, 2014, as cited by Miller & Minton, p. 1). IPA involves a "double hermeneutic" in that it seeks to understand the study participant's sense of their experience and integrates that with the researcher's understanding of how the participant makes sense of their experience (Creswell & Poth, 2017; Smith & Osborne, 2015). IPA also has its theoretical foundation (Smith & Osborne, 2015). The theoretical foundation is comprised of three elements: 1) phenomenology as a philosophical approach that is designed to produce an account of lived experience without prescriptive theoretical approaches, and 2) phenomenology as an interpretive approach with the researcher making sense of the meaning of the experience of the participant 3) phenomenology is committed to idiography and examines the detailed experience of each participant on its own before moving to the common essence of the experience. IPA provides the opportunity to examine the issues of race, racism, and white supremacy. Researchers and scholars have used IPA to unpack and underscore the experiences of racism and white supremacy individually but also contextualize the experience of the participant within structures/systems of white supremacy (Acheson, 2006; Beharry & Crozier, 2008; Birzer & Smith-Mahdi; Giwa, 2018). IPA also allows for the personal and political activism that racial justice work suggests (Acheson, 2006).

IPA is congruent with the research to understand the experience of white healthcare providers doing racial justice work. "Although, generally, phenomenology tries to push off theory in the sense of abstractive science, phenomenology may also bring in theory when

exploring a standing problem or nature of things (Cypress, 2017, p. 17)." The critical theories that led the researcher to the research question provide the sociopolitical context by which this question becomes important. CRT and CWS help the researcher develop research questions and interpret the sociopolitical context from which the detailed data emerges.

While there is some debate about the role of theory in IPA (Smith et al., 2009), IPA's fluidity can also withstand the biases and assumptions the researcher brings to the research (Finlay, 2009). "Paradigms used by qualitative researchers vary with the set of beliefs they bring to research," and they should make their paradigm transparent as they approach the research (Cypress, 2017, p. 208). With this in mind, the theoretical underpinnings of CRT and CWS are congruent with IPA and will work in tandem with its materialist underpinnings. Other researchers using IPA may stick closer to social constructionist viewpoints that embrace multiple meanings (Newberry, 2012); however, IPA offers a clear path to unpack and critically examine race, racism, and racial justice work.

The fit of the research question with phenomenology is fundamental to the research. Van Manen (1990; as cited by Starks & Trinidad 2007, p. 1374) explained that "phenomenologists ask questions about lived experiences, as contrasted with abstract interpretations of experience or opinions about them." This emphasizes the importance of the congruency between how the research question is framed and the approach to the research (Starks & Trinidad, 2007). The research questions were: 1) What is your (white healthcare provider's) experience of racial justice work in healthcare? With this question, the researcher hoped to hear about the activities and all the things that participants had been involved with pertaining to racial justice work. 2) How do you experience racial justice work in healthcare (Creswell & Poth, 2017; Moustakas, 1994)? With this question, the researcher hoped to hear about the thoughts, feelings, and

potential motivations for their involvement in racial justice work. These questions allowed the researcher to unpack the embodied experience of the phenomenon she researched.

IPA has been used in several works that seek to understand racialization experiences (Acheson, 2006; Al-Saji, 2014; Birzer & Smith-Mahdi, 2006; Giwa, 2018; Lee, 2014; Yancy, 2014). The researcher's ontological and epistemological beliefs are materialist, like the assumptions underlying IPA. IPA seeks to understand the essence of the lived experience of the phenomenon (racial justice work) and will honor my values as the researcher and the values of the research participants. "Researchers are encouraged to bring their diverse perspectives and content applications to the research process while utilizing IPA principles as a launching point to coincide with the research question, research purpose, and research paradigm (e.g., critical, postmodern, feminist, social constructionist; Miller & Minton, 2016, p. 2)." In undertaking this research, the researcher acknowledged her knowledge (from the literature review and personal experiences), beliefs, feelings, and biases about health inequities and disparate outcomes for racialized people and my doctoral purpose for the research product. The nature of the research question aimed to get at the experiences of "white" healthcare providers involved in "racial justice work." The ability through IPA to contextualize the research participant (white healthcare providers) and the experience of the participant (with racial justice work) within the social structures and institutionalized systems of racism and white supremacy within society and healthcare (Bailey et al., 2021) allow the researcher to unpack how these white healthcare providers are seemingly working *against the grain*, and potentially against the privilege that is imbued in their identity as a white person.

While several IPA researchers prefer a bracketed approach (Cypress, 2017; Smith et al., 2009; Smith & Osborn, 2015), others express more flexibility (Crist & Tanner, 2003; Miller &

Minton, 2016; Zahavi, 2019b). Zahavi (2019b) explains that epochè reduction is unnecessary for the "double hermeneutic" the researcher sought to bring to the research. The researcher does not believe that research can be value-neutral. Therefore, she acknowledged her bias and reflexively allowed the research data to emerge. This provided an opportunity for deeper reflection and led to a more significant excavation of the stories of the lived experiences of the research participants (Beharry & Crozier, 2008; Crist & Tanner, 2003; Creswell & Poth, 2017; Finlay, 2009; Giwa, 2018; Neubauer et al., 2019; Smith et al., 2009).

Phenomenology assumes that the researcher seeks to understand the common meaning or essence of the lived experience of a concept or a phenomenon that led the research. However, CRT and CWS, which drew the researcher to the phenomenon, helped focus and guide the researcher's understanding and interpretation of the phenomenon's social, cultural, and historical context (Cypress, 2017; Cronin & Lowes, 2015; Neubauer et al., 2019). The theories also gave the researcher insight into developing research questions as the research progressed.

Methods

The final sections of this chapter discuss the methods for the research. This includes a discussion of the methods of data collection and data analysis and interpretation. IPA does not approach methods with an entrenched set of rules for the process; however, there are some expectations about data collection and data analysis to produce the essence of the meaning of the phenomenon (Cypress, 2017; Smith et al., 2009). The rigor of the data collection through in-depth interviews and data analysis through careful, detailed iterative reading and re-reading of the data helped to reveal the meanings' essence (de Witt & Ploeg, 2005).

Data Collection

Research Setting

The researcher recruited white healthcare providers, including doctors, health scientists/researchers, nurses, and social workers from healthcare settings (institutional, community settings, or any location where the abovementioned participants worked). All research participants were from the U.S. As discussed later, the researcher followed all institutional ethical guidelines, including obtaining informed consent from the participants in the sample and REB requirements (See Appendix B).

Sampling Study Participants

While IPA does not have a set method for the sampling strategy, the essential point is to collect data from individuals who have experienced the phenomenon (Patton & Cochran, 2002). In seeking the common experience of white healthcare providers involved in racial justice work, "data from only a few individuals who have experienced the phenomenon—and who can provide a detailed account of their experience—might suffice to uncover its core elements" (Stark & Trinidad, 2007, p. 4). The participants in this study included self-identified white healthcare providers involved in racial justice work. The inclusion and exclusion criteria for the sample flowed from the conceptualization of white healthcare providers as self-identified white doctors, health scientists/researchers, nurses, and social workers who are involved in the racial justice work to ensure the group shares the common characteristics of identifying as white, a healthcare provider, and engaged in racial just work (Crist & Turner, 2003; Patton & Cochran, 2002). Racial justice work was operationalized as activities (indicated by the study participants) designed to tackle racial injustice in healthcare on behalf of or with racialized people. The researcher screened potential participants using the following inclusion criteria:

- Self-identify racial identity as white.

- Self-identify as a healthcare provider (doctor, health scientist/researcher, nurse, or social worker).
- Self-identify as being involved in racial justice work defined as activities (indicated by the study participants) designed to tackle racial injustice in healthcare on behalf of or with racialized people.

Purposive Snowball Sampling

The sample size for a phenomenological study can range from one to ten individuals, with the unit of analysis being the accounts of the experience of racial justice work (Starks & Trinidad, 2007). The small sample size is intentional in that the unit of analysis becomes the rich, detailed accounts of the participants. The small sample size allows for careful reading and re-reading of the accounts (Smith & Osborne, 2015). I used purposive sampling to allow for the systematic and transparent collection of the sample (Morris, 2006; Patton & Cochran, 2002). Snowball sampling enabled a process by which white healthcare providers involved in racial justice work could identify others from within their network who self-identify according to the criteria of the sample (Creswell & Poth, 2017). Using purposive snowball sampling (Morris, 2006), my goal was to identify 10-20 (Creswell & Poth, 2017) white healthcare workers involved in racial justice work within their healthcare setting.

Research Ethics Board and Ethical Obligations

Before beginning, the researcher applied for approval from Memorial University of Newfoundland and Labrador's Interdisciplinary Committee on Ethics in Human Research. The research ethics board found the study to comply with Memorial University's ethics policy. To identify participants, the researcher created a recruitment email (Appendix A). The recruitment email contained the following information: a) an overview of the study and objective of the

research, b) study eligibility information, c) a description of the voluntary nature of study participation or dissemination of the recruitment email, d) the measures taken to ensure anonymity, e) the steps to enroll in the study, and f) my contact information as the research principal investigator and contact information of my doctoral research supervisor and the research ethics board.

The researcher sent the study recruitment email to professional listservs and invited anyone who saw the study information to share it with their networks. The researcher avoided emailing anyone she was associated with in a positional authority relationship or who might be afraid of penalty or hope for reward by participating or disseminating the study information. The purposive snowball sampling yielded 53 people, of which 22 people met the criteria and chose to participate in the study. (Chapter 5 provides more information about the sampling method and study participants.)

Data Collection Generation

The researcher collected data using a demographic survey, semi-structured individual interviews via Zoom, and reading of any documentation considered relevant to a participant's experience of racial justice work (Crist & Turner, 2003; Bradbury-Jones et al., 2009). She journaled any field notes of ideas and themes that emerged during the interviews. The demographic survey and individual interviews were the primary sources for the data (Crist & Turner, 2003; Starks & Trinidad, 2007). She collected data via two internet platforms, Qualtrics for the demographic survey and Zoom for the interview. Zoom interviews were recorded and transcribed via the Zoom platform. Both platforms, Zoom and Qualtrics are HIPPA compliant (See Appendix B for links to Zoom and Qualtrics HIPPA statements).

The demographic survey included an eligibility screening component using embedded skip logic to ensure eligibility inclusion and exclusion criteria were met. Participants were reminded that they could skip any questions they did not want to answer. Survey participants were screened according to study eligibility and given the researcher's contact information if they felt they were incorrectly screened out of the survey. If study participants met eligibility criteria, they were directed to the embedded informed consent, and after signing the informed consent they were able to set an appointment for the interview with the researcher. The demographic survey allowed the research to capture demographic information (i.e., gender identity, sexual identity) that helped me to better understand my sample beyond the scope of the semi-structured interview. The demographic survey demonstrated the intersections of the participant's other identities with the participant's race and occupation (See Appendix C for Demographic survey).

The semi-structured interviews included broad themes capturing participants' definition of the phenomenon, how they understood their experience of the phenomenon, and how they envisioned and made sense of the next steps in relation to the phenomenon (See Appendix D for Research Instrument). At the beginning of the Zoom session, the researcher reminded participants to change their Zoom screen name to their pseudonym and addressed them using their chosen pseudonym throughout the interview. She also reminded participants that they could skip any questions that they did not want to answer during the interview. Adhering to the ethical guidelines for confidentiality and consent, she recorded in-depth semi-structured individual interviews via Zoom and utilized Zoom transcription.

During the interview, the researcher observed the participant, avoided interruptions, and allowed the participant to answer the questions as they determined. If the researcher did not understand their meaning or their response was otherwise unclear, she asked the participant to

repeat what they stated or clarify what they understood the phrase or term in question to mean. Depending on the individual participant and the depth of the responses, if participants needed additional time to answer questions, the researcher offered to extend the interview time. The researcher also asked additional questions of some participants, as needed, to clarify their responses (Crist & Turner, 2003). The researcher allowed the data to help shape any additional follow-up questions. The research questions described earlier in the text were generated from the research goals. However, the questions used in the interviews emerged and developed as the essence of the experience of racial justice work unfolded (Crist & Tanner, 2003). More questions arose during the iterative process; the goal was to produce rich descriptive accounts of the experiences.

Data Storage

For data storage and management, the researcher kept the key aspects of confidentiality and anonymity in mind and adhered to processes to ensure that safety and ethical concerns were addressed (Silver & Lewkins, 2014). Recorded interviews were stored on a secure server. The researcher utilized the digital software Dedoose. Dedoose is a subscription-based software with several layers of encryption. (See Appendix B for Dedoose Security.) The researcher used Dedoose to store and electronically categorize my transcripts via memoing and coding. The researcher maintained confidentiality with all of the notes, transcripts, and recordings. During the demographic survey, participants were asked to assign themselves a pseudonym. As an additional layer of protection, each audio recording, transcript, and note was then assigned an alias, i.e., “Jonathon,” and actual participant identifying information, their chosen pseudonym, and alias were stored separately. The researcher made an encrypted folder with different

subfolders for audio recordings, transcripts, field notes, consent agreements, or other research documents (Patton & Cochran, 2002; Silver & Larkin, 2014).

Data Analysis and Interpretation

The researcher patterned the data analysis in the iterative process outlined by (Smith et al., 2009) and interpreted by Pascal (2010) as follows:

Table X Iterative Data Analysis Process

Immersion (Iterative)	
Step 1	Reading and Rereading
Step 2	Initial Noting
Step 3	Developing Emergent Themes
Illumination and Explication (Iterative)	
Step 4	Searching for Connections Across Emerging Themes
Step 5	Moving to the next participant transcript (case)
Step 6	Looking for patterns across participant(s') transcripts
Explication	

Immersion (Steps 1-3)

The researcher cleaned the data, checking the accuracy of the transcribed the interviews, by listening to the recorded interview and verifying the content in the transcription. As the researcher completed this task for each interview, the process increased her familiarity with each interview and the similarities and differences across interviews. As applicable, the researcher also reviewed notes taken during the interview process. Next, in a circular process, the researcher carefully read and re-read the data to begin a process of initial notations and commentary to

identify emerging themes from each transcript. The circular process of gathering data, examining it, and asking new questions helped to produce richer knowledge of the phenomenon. With this in mind, she coded the data generated. The researcher created a framework of codes and groups to cluster the data into categories. The study's data yielded 44 initial codes through reading and re-reading the transcripts. Keeping in mind that the circular process of data collection and data analysis was producing additional questions and angles, the researcher analyzed the emerging themes of the data and collected additional data from those themes. As the researcher examined the themes that emerged from my data clusters, she critically analyzed these themes looking for similarities and differences within the data, gaining more insight into intersections of the themes that the data revealed (Smith et al., 2009; Hefferon & Ollis, 2006). The data led to different questions and additional points to consider.

Illumination and Explication (Steps 4-6)

As the researcher identified the themes and the connections across the emergent themes, she referred to the identified list of themes. This helped her begin to recognize saturation or new themes (Hefferon & Ollis, 2006). The researcher also looked for patterns across individual responses and within the group responses. The researcher's critical reflections on the data guided by her theoretical lens and her lived experience played a role in her understanding, exploring additional questions, and interpreting the essence of the white healthcare providers' lived experiences of racial justice work (Creswell & Poth, 2017; Graham et al., 2011). The researcher was open to inductive themes emerging from the data or theoretically informed themes emerging or a combination of inductive and theoretically informed themes emerging during the research and iterative analysis of the data. The researcher iteratively combed through the data, writing

textual and structural descriptions of participants' narratives (as highlighted in their quotes) to demonstrate the emerging themes (Giwa, 2018).

Explication

Utilizing CRT and CWS, the researcher developed and wrote a composite description combining the textual and contextual descriptions of the essence of the white healthcare providers' experiences of racial justice work (Creswell & Poth, 2017). The textual analysis allowed the researcher to understand how the participants made sense of their experiences through what they said about the experiences (Hawkins, 2017). The contextual analysis allowed her to place the participants' responses about themselves (including their demographic survey responses) and their racial justice work into the social and cultural circumstances and contexts of their lives and current personal and societal events (Creswell & Poth, 2017). As this is not a linear process, this process continued until no new information emerged from the data or a point of saturation of the data was reached (Boddy, 2016; Crist & Tanner, 2003; Patton & Cochran, 2002).

Ethics

An ethical research approach is the first step in ensuring that the researcher minimizes harm to participants (Rubin & Babbie, 2016) and that the research produces relevant and applicable results (Nowell et al., 2017). In addition to the institutional review of the proposed study, the researcher must apply rigor to the methodological approach of the qualitative research and reflexivity to minimize the impact of bias on the research (Rubin & Babbie, 2016). This section discusses the researcher's rigorous adherence to the procedures for data collection and data analysis, which yielded the trustworthiness and validity of the methods to produce research results that are transferable and credible.

As mentioned in this chapter, the researcher applied for and received ethics review approval from the institutional Research Ethics Board. The institutional review board determined that the researcher should not directly contact any potential participants before they contact the researcher and consent to the study. This directive was intended to reduce the potential for participants to feel pressured by the researcher to participate in the study. The researcher adhered to this recommendation and recruited study participants via professional email listservs and invited anyone who saw the study information to share it with their networks. Research participants were not solicited and did not volunteer from the pool of people she supervised or who otherwise might have felt obligated to participate because of her positional authority, a hierarchal relationship with her, fear of penalty, or hope for reward. Purposive snowball sampling allowed the researcher to disseminate information to a broader audience and recruit additional participants. While the passive approach outlined by the Research Ethics Board yielded a smaller sample than may have been possible, it maintained the ethical approach directed by the institutional Research Ethics Board.

Abiding by the directives of internal review boards for research ethics is fundamental in research. Trustworthiness and validity in the research process are essential for the researcher's doctoral journey and publications standards, and transferability and credibility of the research findings are critical in upholding an ethical responsibility to the research participants. Terms like trustworthiness and validity are controversial when applied to qualitative research. For instance, when used in research, trustworthiness may be meant to imply that the research was “objective” and may suggest to some that research can be “value-neutral.” This researcher believes all research is value-laden and applies the term trustworthiness to indicate the rigor employed in the research methods. Trustworthiness was achieved by adhering to a transparent Research Ethics

Board-approved process for the sample selection. The researcher also adhered to a transparent and systematic procedure for data collection. As noted earlier in the chapter, the researcher utilized semi-structured individual interviews for data collection. The researcher used a technique called member checking, whereby participants could view and retrieve the live transcription of their interview as it was created during the Zoom interview. Participants were invited to repeat or change their statements if they felt their intended meaning was not accurately reflected (Groenewald, 2004; Hefferon & Ollis, 2006).

Methodological rigor and a systematized data analysis process enhanced the research's trustworthiness. IPA's iterative data analysis process and systematized interpretation of the data involved the researcher making sense of the participant's sense-making of the phenomenon. The data analysis included systematic coding, memoing, and theme generation, producing more questions. The researcher's reflexivity during the process of coding and memoing facilitated reading and re-reading of the data to avoid and minimize bias. While the researcher does not believe that any research is value-neutral, reflexivity allowed the researcher to acknowledge her bias. The transparent, systematic process of the double hermeneutic involved the researcher acknowledging her bias and re-reading the data, seeking to understand the study participants' sense of their experience, and integrating that with her understanding of the participant's sense-making (Creswell & Poth, 2017; Smith & Osborne, 2015).

Validity in qualitative data reflects the suitability of the research process with the research question and the findings (Leung, 2015). The researcher’s use of IPA to examine the experiences of racial justice work allowed the researcher to consider the social context from which the data emerged as she engaged the double hermeneutic of making sense of the participant’s sense-making of the phenomenon. The research design aligned with the

examination of racial justice work and allowed the researcher to examine the social context of the research participant (Leung, 2015). The researcher's rigorous application of the systematic interpretation process of iteratively reading and re-reading the data allowed the common essence of the phenomenon to emerge from the data. The common essence of racial justice work that emerged from the data speaks to the validity of the research design and the findings from the research (Leung, 2015). Utilizing the processes outlined above allowed the researcher to produce trustworthy and valid research that upholds the rigor of the methodology (de Witt & Ploeg, 2005).

The methodological rigor of the IPA research design outlined in this chapter's discussion of sample generation, data collection, and data analysis undergirds the researcher's ethical approach to the research. It enhanced the findings' credibility and transferability. In qualitative research, the aim is to produce recognizable conclusions for those with the experience that are transferable to others with the same experiences. While the small sample size of the qualitative study does not allow for the generalizability of the findings, the transparency of the research design and the thick descriptions allow those who are confronted with the experiences described to recognize the experience, lending to the credibility of the study (Denzin & Lincoln, 2018). Likewise, the methodological processes implemented in the study allowed the rich details of the data to emerge and allow for the transferability of the findings (Tobin & Begley, 2004).

An ethical approach to this research included adherence to the research ethics board directives and implementing methodological rigor to the IPA research design. The qualitative IPA research allowed for reflexive acknowledgment of the researcher's bias and employed rigorous research practices that adhered to the methodological approach to provide meaningful results. The robust research process, produced trustworthiness, validity, credibility, and

transferability of the research and findings. Ethics in this research were fundamental to the research process and the transformative findings from the research.

Moving from silence into speech is for the oppressed, the colonized, the exploited, and those who stand and struggle side by side a gesture of defiance that heals, that makes new life and new growth possible. It is that act of speech, of "talking back" that is no mere gesture of empty words, that is the expression of our movement from object to subject—the liberated voice.

—hooks, 1989, p. 9

Chapter Five: Presentation of Findings

IPA allowed Hefferon and Ollis (2006) "to go beyond quantitative restraints and feel, interpret and understand the experience (p. 157)." IPA allowed the researcher that same experience and yielded refreshed insight into participants' racial justice efforts (Larkin et al., 2006). The findings of this study were captured from the demographic surveys and interviews with study participants. In this section, the discussion describe the demographic data and the participant profiles that emerged of the 22 participants who participated in the interview, and the themes found in the data.

Data from the Demographic Survey

Professions of Survey Respondents

Of the 22 participants, 100% identified their profession as a healthcare provider. Of the 22, 31% (n=7) identified as a doctor, 4.5% (n=1) identified as a health-related scientist/researcher, 27% (n=6) identified as a social work researcher, 23% (n=5) identified as a social work educator, and 4.5% (n=1) identified as a social work health manager and 9% percent (n=2) identified as a nurse or nurse scientist.

Age of Survey Respondents

For survey respondents who responded to the survey question about age, the age range varied, with most of the participants identifying as between 41-50 years old (n=12) constituting

the largest participant age group, followed by 31% identifying as between age 31-40, and 29% identifying as age 50 or over.

Gender Identity and Sexual Orientation of Survey Respondents

For survey respondents who responded to the survey question about gender identity, 60% of respondents self-identified as female, 31% self-identified as male, and nine percent self-identified as gender non-binary. For survey respondents who responded to the survey question about sexual orientation, 11% self-described as queer, nine percent self-described as either bi-sexual or pan-sexual, nine percent self-described as either lesbian or gay, and 71% self-described as either heterosexual or straight.

Socioeconomic Status in Childhood

For survey respondents who responded to the survey question about their socioeconomic status in childhood, 54% self-identified as being in a middle socioeconomic status during their childhood, 37% self-identified as being in a high socioeconomic status during their childhood, and 9% self-identified as being in a low socioeconomic status during their childhood.

Interactions with Black, Indigenous, or Other People of Color

For the survey respondents who responded to the question about their interactions with Black, Indigenous, or other people of color, approximately 83% said they interacted with Black, Indigenous, or other people of color two or more times per week, 14% said they interacted with Black, Indigenous or other people of color at least one time per week, and three percent said they interacted with Black, Indigenous or other people of color infrequently.

Parents Frequency of Engagement with Social Issues

For the survey respondents who responded to the question about how engaged their parents were with social issues (during their childhood), approximately 51% responded occasionally involved, 37% responded not involved, and 11% responded very involved.

Exposure to Racial Justice Conversations/Information as a Child

For the survey respondents who responded to the question, were they exposed to racial justice conversations/information as a child, approximately 46% responded yes, 51% responded no, and 3% did not remember.

Family's Regular Attendance (during childhood) and their Regular Attendance as an Adult at Religious Services (pre-COVID 19)

For the survey respondents who responded to the question, did your family regularly attend religious services during your childhood, approximately 57% said no and 42% said yes. When asked did they regularly attend religious services as an adult (pre-COVID-19), approximately 60% said no, 11% said infrequently, once, or twice per year, 20% said occasionally, one or more times per month, and nine percent said yes, one or more times per week.

Other Information about their Identity Respondents Shared:

"I am a family physician working in a federally qualified health center (FQHC) in a rural area, with a patient population that is about 50% white and 50% non-white (the latter mostly African American and Haliwa-Saponi Native American). A large portion of our patients are also uninsured or underinsured."

"White woman partnered with a Black man. Two young sons, living in close community with my white parents & extended white friend group."

"American"

“Growing up in a working class single-parent family and being non-Christian are central to my identity and commitment to anti-racist/restorative equity practices.”

“I am third generation Jewish American. I am a Buddhist.”

“Disabled, chronically ill, neurodivergent.”

“I identify as polyamorous.”

Interview Participation

Ultimately, 22 people scheduled an interview and participated in the research interview. These survey respondents consented to participate and were successful with scheduling an interview and showing for the interview. The research ethics board determined that it would not be ethical for the researcher to contact people directly. So, erring on the side of caution, if respondents did not follow-through with appointments they set for an interview, they were automatically sent one reminder from the internet scheduler of how to contact the researcher or how to reschedule a time for the interview. The researcher did not reach out directly or continue to follow up to reschedule the potential research interviews.

For IPA, a small sample size is appropriate because the unit of research is the rich detailed excerpts about the experience of the phenomenon compiled from each interview. Therefore, 22 participants for this IPA study were above my goal for participant numbers, beyond the requirements for IPA, and more than sufficient to obtain data about the phenomenon. The interviewees included, two (n=2) nurses, seven (n=7) doctors (from a variety of medical disciplines), one (n=1) health-related scientist/researcher, six (n=6) social work researchers, five (n=5) social work educators, and one (n=1) social work health manager. These 22 participants garnered over 2,359 data excerpts. In keeping with research ethics, as promised to participants, additional demographic data from the 22 participants has been intentionally withheld, due to the

danger of jeopardizing the anonymity of participants. Many of the participants are well known and prolific in their disciplines/fields for their racial justice work and specialty areas.

Moving from silence into speech is for the oppressed, the colonized, the exploited, and those who stand and struggle side by side a gesture of defiance that heals, that makes new life and new growth possible.

—hooks, 1989, p. 9.

Themes in the Data

———The semi-structured individual interviews produced rich detailed descriptions. Three comprehensive and intersecting themes emerged from the data 1) Omnipresence of Racism and White Supremacy; 2) Anti-racism (racial justice worker) Identity Development; and 3) Reconciling Racism and White Supremacy in Healthcare. The final portion of this chapter explores each of these themes and their subsequent sub-themes in greater detail utilizing the data supporting the themes and sub-themes. This discussion of the themes is divided into three sections. Each section explores one theme and utilizes the data to explicate the corresponding sub-themes.

Section One

Theme One: Omnipresence of Racism and White Supremacy

The first theme, "Omnipresence of Racism and White Supremacy," describes participants' perceptions of racism and white supremacy as always present. The following three sub-themes emerged from the data under the theme Omnipresence of Racism and white Supremacy. The three sub-themes were 1) whiteness/white Supremacy is Visible and Invisible; 2) Racism Is; and 3) Racialized Trauma. Participants noted how racism and white supremacy were part of their personal and professional socialization. They noted the constant messages they received from their environment that affirmed the normalcy of racism and white supremacy. This theme narrates the life-world of the participants, what they witness, participate in, reject, or accept in terms of living in a world that they deem as full of racism and white supremacy. The data in this section illuminate the dominant/ worldview that often denies de jure racism and gives insight into the consciousness of white healthcare providers. It brings the life-world of the white healthcare providers into focus and the omnipresence of racism and white supremacy.

Sub-Theme One: whiteness/white Supremacy is Visible and Invisible

The first sub-theme of the theme Omnipresence of Racism and white Supremacy is "whiteness/white supremacy is visible and invisible." Participants describe the pervasiveness/insidiousness of white supremacy and whiteness across temporal, spatial, material, and intrapersonal domains. Ava says, "[white supremacy] is a pervasive sort of state of being." Participants place white supremacy as birthed within historic colonial systems but also express the continuity of modern colonialism and situate white supremacy within the coloniality that they currently witness throughout the world. Jacob says,

> "I think white supremacy is baked into the world and western civilization through a process of coloniality that has lasted centuries and continues…. And so [white supremacy] it's, not only in North America, but it's in Europe and on, and you know I've taught in China, and I do work in Uganda and in Sri Lanka and I've seen how racism is operating there, but white supremacy is always central to it."

Kevin's statement gets at the intricacies of how the system of white supremacy was created and is continued. He says, "I think the idea is if you're on top, if you're really worried that your group is going to lose their power, societal position, or their value-positions that say that they are superior, well, you can try to make laws and practices that are obviously bad for certain other groups of people or certain ways of life." He and other participants located this within socio-political structures undergirded by elections and white majority systems of power. As with other participants, Liam gets at the intractability, "embeddedness," the "identifiable" and "visible" harm of systemic white supremacy.

> "This country has so many structures … that are rooted in racial imbalance and racial discrimination, you know the penitentiary system, you know the justice system, you know the gross imbalance in laws that are focused on behaviors that were historically associated with African Americans, like you know the amount of people who are serving jail time for petty marijuana possession. I mean compared to crimes that are more commonly associated with white people, that have far shorter sentences. It's the system, it is designed to trample on, to keep down African Americans, it's embedded [with white supremacy].

Participants' descriptions place white supremacy as everywhere. Their descriptions implicate the material and intrapersonal reach of white supremacy.

While participants located the origins of white supremacy as tied to phenotypic characteristics and colonialism, participants also perceived white supremacy as extending into all facets of identity and existence beyond phenotypic characteristics. According to Remi, white supremacy encompasses "certain ways of being, knowing, communicating, creating, sharing in a way, that upholds, and affirm systems of power, including but not limited to whiteness, masculinity, heterosexuality and 'cisgenderedness', non-disabledness, class, and money, money, money." Participants stated that white supremacy was visible in the systems and institutional processes that valued Eurocentric knowledge and ways of interacting but devalued other groups' knowledge. Liza says, "[white supremacy] it's an assumption of conquest, it's an assumption that as white people, we have a right to take up space, to define norms, to kind of set agendas and we have a right to exclude whoever we deem undeserving, or unworthy, or outside." Other participants described the visible historical and contemporary impact of white supremacy that ties into the material benefits of being accepted into whiteness. Tessie said,

> "There have been explicit and deliberate decisions and actions made that have created benefit for white people, everything from what's available in terms of the inheritance of wealth, what's available in terms of housing stock, what's available in terms of government programs. Like the GI bill was not available to most of the African American people, these [programs] were defined in a way that excluded African American people and people who are not white, so that made it impossible to participate in the supposed liberties and freedoms of a nation and it's been going on ever since."

Under this sub-theme, participants used the terms whiteness and white supremacy interchangeably. Participants suggested that white supremacy is a system based on power and privilege that is determined by the individual or group's proximity to whiteness. The participants

perceived white supremacy to be perpetuated through “whiteness.” Whereby “whiteness” is the “ideal” version of being, with standards set by white supremacist ideology about who and what are acceptable based on the supremacy of western Eurocentric ideals. According to the data from participants, whiteness in turn is a belief system determining what is valued or deemed ideologically valuable in society. Jacob says, “so [white supremacy] it's a belief system, but it's also an institutional historical process that, like I said, bakes it in.”

Whereas other participants determined that some manifestations of whiteness and white supremacy are embedded and can be imperceptible. For example, Emily explains that white supremacy and whiteness is invisible.

> “The fact that whiteness is the default in terms of how our society and culture is organized and we don't often see that whiteness is the default. You know there's that image of the fish and the fishbowl, [the fish] not knowing that it's in the water kind of thing, but basically [white supremacy] it's a structure of domination [white supremacy] it's a structure of oppression, for people that are not in the white group.”

Liam points to the invisibility and perpetuity of white supremacy. He says,

> “The fact of the matter is that the majority of white supremacist leaning white Americans have been educated to believe that way. Yeah, it is, the systems and the societies and communities in which they live, that actually believe that, so it's just passed down…I think that most white supremacists don't achieve that viewpoint, based upon a deep kind of rummage through the literature, or through a kind of moral and ethical standpoint. I think they believe that [white supremacy] because it has been drummed into their psyches from birth.”

Remi gets at the imperceptible ways that white supremacy is “activated.” They say, “[White supremacy] is activated in a variety of ways that have been woven through our politics through the constitution but also even in how much of our society was built whether we're talking about on the backs of stolen people or on the backs of stolen land.”

According to the participants, the visibility or invisibility of whiteness/white supremacy rests in the socio-political location of the observer, the obscurity of the legal and socio-political system underpinnings, and the observer’s entrenchment in whiteness. Remi says, “So, I don't know if you can understand white supremacy without also bringing in capitalism, and Christianity, and colonization, and ableism, and, to some extent the cis-hetero patriarchy as well, these are the beliefs that undergird every aspect of our society that center whiteness, ‘able-bodiedness,’ and ‘able mindedness.’” Riley explores the perpetuity of white supremacy, “so it's not just an idea that's held in a head, but it's an ideal that is sort of saturating across systems and creating structures that maintain it and hold it, sort of accountable to itself, and once it's there it's hard to get rid of, because it reinforces itself in super problematic ways.” Finally, Loretta says, “white supremacy, in and of itself, is inherently harmful. It's a set of beliefs, that are harmful, and its harm is part of the intention of the system of white supremacy.”

The participants in this sub-theme situate whiteness and white supremacy within the sociopolitical context and name their relationship to it. The act of naming and recognition brings forward the racial consciousness that is often dismissed, silenced, or missing from the discourse or the foundation for action of the majority of white people. Participants bring forward what has been invisible, unnamed, and yet, —what has formed the essence of their embodiment within the social context they inhabit.

Sub-Theme Two: Racism Is

In the sub-theme "Racism is" participants linked racism and white supremacy and saw racism as the exercise of white supremacy. Tessie's characterization of racism as a function of white supremacy or a system "that predominantly benefits white people" offers the perfect segue into the second theme. Tessie says,

> "it's the systemic misuse of power in a way that effects people who have a racial identity other than white, racism is an effect of white supremacy, a system of social and economic and other kinds of outcomes that predominantly benefits white people at the cost of people who are not white."

Jacob describes his understanding of white supremacy; "what it [white supremacy] means is that white people have greater access to resources, wealth, power and have constructed the socio-economic, political system in a way that benefits white people at the expense of BIPOC [Black, Indigenous, or other People of Color]. In agreement with Tessie and Jacob, Remi offers, "from an active definition standpoint, I think racism is the embodiment of white supremacy… racism is the privileging and abusing of non-white entities or anybody who doesn't embody, invoke, and pass with whiteness."

Liza said, "it's more than just disparities and inequality, it is a real dehumanization and devaluing of people of color and with that comes a willingness to sort of either inflict or tolerate various levels of violence." This sub-theme illuminated the nature of racism as historical, structural, interpersonal, and intrapersonal and intersecting across these domains. Table 4 provides the participant's descriptions of the historical, structural, interpersonal, and intrapersonal.

Table 4. The nature of racism across intersecting domains

Nature of racism	Participants' quotes
Historical	Riley: "it means this identity or these groups of people that have been thrown together through historical power structures to be you know, a grouping that society now sees as a "thing" and it's often historically understood biologically but that's false, and often hierarchicalized through power and those different things."
Structural	Amelia: "racism is something that's been institutionalized or sort of built into the fabric of our country here in the U.S. as a whole, but certainly into our system." Loretta: "the institutionalized and systems mechanisms that have developed from individuals in power being able to create systems and policies that typically, have poor outcomes for people of color or individuals, based on race, ethnicity or country of origin." Jonathon: "so I understand [racism] it to be not necessarily acts of bigotry but simply

	having institutional access to power and benefiting from systems of discrimination."
Interpersonal	Loretta: "in general, a set of thoughts, feelings, or behaviors of bias that can be experienced by an individual towards a particular group based on race." Emily: "I think of racism…as something that can be interpersonal on the micro level that oppresses people of color." Chloe: "a person treats someone of a particular race differently, because of that [race]." Rowan: "I would define it as either some type of intentional or unintentional differential treatment of a group of people, based on a racial construct."
Intrapersonal	Jacob: "intrapersonal you know where people internalize white supremacy if they're white or internalize negative self-concepts if they're the targets of racism as happens to some BIPOC [Black, Indigenous, People of Color] people."

Charlotte determined, “I would define [racism] it as all of the structural and systemic impacts that impact certain people based on physical characteristics that we describe as race that lead to inequities across a range of outcomes.” On the other hand, Riley contextualizes and broadens the characterization of racism, “there's other definitions, if we're talking about racism broadly, we would talk about things also like [how] religion has been used to create races, or geographical living situations have been used to create races among humans.” Owen says,

> I don't know what non-racism is; I think [racism] it's so ingrained within society, it is within individuals, living in our bodies. [Racism is] within all bodies, institutions, systems, structures, individuals, and I think [racism] it's, much deeper and much more ever-present and overwhelming than what I was taught to believe.

Jacob summarizes by describing the “*spectrum of racism*, I think that racism ranges from historical, institutional, structural, collective, group, to interpersonal, to intrapersonal…so, it's a complex thing trying to define racism, because it is all these different things, and they all interact together, they're never separate.”

Participants described their life-world in which racism is acknowledged and inherent in their sociopolitical context. Their contextualization of how they make sense of racism, how racism is enacted and employed, and where racism manifests point to the lens that they use to situate their racial justice work. Participants’ descriptions of racism as fluid and used to create or open barriers for different bodies in different spaces across time to enact benefits or consequences complicate their embodiment of white privilege and power. The marking of the domains of racism implicates them as white people and calls upon them to enact anti-racism.

Sub-Theme Three: Racialized Trauma

The third sub-theme under the theme of the Omnipresence of Racism and white Supremacy is "Racialized Trauma". This sub-theme consisted of participants' perceptions of the impact of racism and white supremacy on Black and other people of color. Participants' perceptions of racialized trauma included knowledge from interpersonal interactions, professional knowledge, and scientific inquiry into the impact of racism and white supremacy on the bodies and minds of Black and other people of color. Data under this sub-theme situated racial trauma as occurring historically and contemporarily. As white *healthcare* providers, the knowledge of being part of a system inflicting racialized trauma "always" implicates them and the systems they participate in consciously or unconsciously.

Participants noted the impact of white supremacy and racism as causing historical racial trauma with residual generational impact across physical, psychological, and life domains and as causing present-day harm and re-traumatization. Participants noted that racialized communities are not "homogenous" and that some individual Black and Brown people have experienced "exceptions" that the group has not experienced. Loretta says, "you know, no community is homogenous culturally, but I [am], you know, looking at a global perspective." Ava says, "white supremacy and racism have impacted racialized people's lives incredibly. I mean how it serves to oppress and to decrease opportunity for racialized people everywhere."

Participants also shared their hesitancy to speak to the "knowledge" of the lived experience of Black and other people of color. They mentioned impact and harms that they could only "guess" about. Riley says, "I have data, and I have science, and I have experiences…but I am not those people [Black or of Color], so I don't want to speak for them in a certain way." As Riley mentioned, Liza says, "this is something that I think in some ways, I can find places to

resonate with, but I am sure that I will never fully understand what it is to move through the world every day feeling at some level unsafe and at some level objectified and dehumanized." Participants' acknowledgment of their *limitations* of "knowing" and "seeing" stand in stark contrast to white supremacist logics and their wrestling with the dominant life-world they inhabit.

Post-racial society. Participants also spoke to the discourse of a "post-racial society," the idea that racial equity had been achieved, and the impacts of racism and white supremacy as a thing of the past. This rejection of a post-racial society gets at their conceptualization of the need for racial justice work. Charlotte shared that the idea of post-racism is a mechanism of white supremacy. She said,

> It [white supremacy and racism] also, I think, creates a system that, in order to maintain white supremacy, it has to convince white people that there's not a problem right. It has to convince them that this doesn't exist, this is something of the past, this is no longer in our present. And anybody that's telling me differently, is trying to manipulate you or to use you or to make you feel bad or guilty.

Riley discusses the conversations around a post-racial society after President Obama's election.

> Yeah, Obama's President, racism is over. Yeah, I mean, …when you have one person who is so successful and that becomes the narrative and then all the rest, you know who are forgotten because of that narrative that is a real problem, so I would challenge people to yes, value those stories, but also ask why, and look at the data and look at yes, maybe that's 1% of the people, and you know and yes, people can get through a lot of things, but we still have a lot of people that [don't].

Charlotte discusses how the battle to describe the experience of racism becomes another layer of white supremacy and racism to be dismantled. She says,

> and so, kind of in doing that [denying or discounting the experience of racism] it creates a different fight for people of color to have to have then, to just convince other people that these things that exist for them are there, when the system in itself is trying to convince white people that they're not there.

Riley also says,

> you know, and so that's one of the things that we do a lot when it comes to race-based education is like, thinking about, let's look at the trends, let's look at the systems and the overarching data that shows us like, yes, there might be a few [Black] people that slip through the cracks of those systems because they're having some sort of ability to do that. But ultimately when we're looking at the broad strokes across our society that's not the reality for most [Black] people and if you're going to reject the data, then that's a whole different conversation to have.

While racism and white supremacy are intentionally discounted and dismissed in the dominant narrative, participants saw the impact of white supremacy and racism as far-reaching and comprehensive. Caroline says, "I would say racism and white supremacy have impacted racialized people's lives detrimentally, stressfully, economically, you know just a disadvantage in life from the jump in most all arenas." Loretta adds, "Also not just resources to thrive, but basic needs have often been denied to communities of color and that has been specifically because they have been co-opted or withheld by white communities." Participants discussed the "alternate reality" that Black people have to exist within. Charlotte says,

> So in addition to creating the barriers, [white supremacy and racism] it's then creating this like alternate universe, where those things aren't *real* for them because *white people don't believe it* or *understand* their *reality*, so I think that it, it creates systems that make it harder for them to achieve their goals and to access the same resources or systems that other people might have more easy access to.

Jacob says, "[white supremacy and racism] it's taking away people's narratives, it's taking away people's voices, it is taking away people's way of thinking, you know their epistemologies how to even think about what this [white supremacy and racism] is and how to deal with it."

Participants' acknowledgement and understanding of the obstacles that racism and white supremacy create in the lives of Black and other people of color provide the context for their racial justice work. Their knowledge and understanding of the psychological, social, and physical repercussions of racism and white supremacy reveal "what" the healthcare providers see/know in the life-world as the parameters and needs for their racial justice work. The following section highlights participants' perception about the socialization into racism and white supremacy that Black and Brown children experience. For some participant's the recognition of how racism and white supremacy impacted Black and Brown children impacted their racial justice journey. They were moved by the stark contrast compared to how they experienced childhood and their [white] children's experiences and life-world. Participants' discussions of the impact of children's experiences with racism and white supremacy reveal some of the white healthcare providers feelings about the life-world they navigate to work against racism and white supremacy.

Impact of white Supremacy and Racism on Children. Participants noted the particular impacts on Black and Brown children. Amelia, says, "white supremacy and racism, it's impacted

every element of someone's [life], what their kids, what they're taught to do and believe and how they're taught to act, and communicate … and to be clear, like a negative impact, often on the lives of racialized people.

Like Amelia, other participants noted the police brutality and murders of Black and Brown people and inequitable institutional treatment of Black and Brown people. Remi says,

> I'm thinking about how they have to talk to their kids about everyone from police to teachers… from going to the grocery store and being afraid that they wouldn't return home, … because they're going to get shot by the police.

Kevin notes that in many families and patients [children] that he talks with, there is exhaustion and a sense of hopelessness that has less to do with disease outcomes and more to do with life. He shares an example that stood out to him,

> I remember asking one kid, I always try to ask this, what are they going to be when they grow up? And this one kid, he was about 14, an African American boy, and he said, 'nothing.' That was pretty scary to me. He was very discouraged. So, you know you, you got to feel empathy for the kids, too. The kids, they see and experience white supremacy and racism.

Liza shares the moment when she realizes that for some Black children as young as three years old, they have already come to a negative association with their racial identity. She relays,

> and there was this, like awful, to the extent that a three-year-old can have, an existential moment. I saw that in her face, and I was just thinking, what is this child carrying through in terms of her identity and her feeling that the world is a safe place to be? Because, for her it's not.

Jonathon continued this discussion describing the impact on children of the explicit and implicit messages and the costs and consequences of white supremacy and racism against Black people. He notes,

> I think about working with a refugee family who recently arrived from a nation in Africa and there was a five-year-old member of the family and when asked what they liked about the United States and what they didn't like, what they identified that they didn't like about the United States was being *Black* and this was from a five-year-old, who had been in the United States for less than a month. That hurt my heart.

Charlotte adds, “racism and white supremacy have impacted the lives of people of color significantly. I think that racism and white supremacy they create a system that's fighting against [racialized people] them from the get-go.”

Participants’ discussion in this section point to their feelings about what they see as the impact of racism and white supremacy. Participants do not spend a lot of time directly discussing their feelings in other sections, while the essence of those feelings does come through. In this section discussing the impact of racism and white supremacy on the Black and Brown children with whom they work, they explicitly name some of those feelings.

Unrelenting Impact of white Supremacy and Racism Across Systems. The feelings of participants reveal how the participants make sense of what they see and their self-assigned racial justice work. This section reveals how participants see their racial justice work within a life-world where the impact of white supremacy and racism is unrelenting across systems. The following discussion indicate the racial justice workers’ knowledge of what they are working for and about. Emily says,

> It [white supremacy and racism] just seems constant whether it's the structural or the interpersonal it is constant awareness, constant radar up constant antenna up for is it going to happen, has it just happened, what am I going to do? You know all that kind of stuff.

Like Emily's comment, Amelia speaks to the sense of surveillance and the uneasiness white supremacy and racism causes for Black people. Amelia says,

> I know from many of my Black friends, you know I wouldn't have thought of this before, but I know that they feel like no matter where they go, they are a little under 'suspicion,' if they are in a place where you know white people are the majority."

Emily, says, "so, it just feels like it must be exhausting to deal with the constant interpersonal stuff and noticing all of the ways the system is set up to disadvantage people of color." Jacob adds,

> there's a chapter that I wrote … which looks at where people can get housing, who can get mortgages, where people can go to school, what access to healthcare, people have and who's targeted by the criminal justice system. l could go through the whole thing… what I'm saying is there's all those institutional impacts [of white supremacy and racism] then there's the physical health, medical, somatic, like the overall [impact of white supremacy and racism].

Liam adds that this history of "otherism" has devastating impacts. Liam says,

> I can only imagine the enormous impact that it has to be to a person of color. You know, to not only have the history of the legacy of "otherism," of being treated and assumed as being a non-human and then to have to make so much effort in the baseline in your life to achieve something that is even quite closely equivalent to the opportunity of a white

> person. Then, once you've made that extra effort, to then be given less opportunity, I think that has to be extraordinarily, you know…, certainly, feelings of injustice.

Aiden adds to Liam's comment emphasizing the broad impacts of white supremacy and racism. Aiden says,

> And then outside of the [health] system and thinking about racism and health inequities. You know, speaking, for example, to that issue of redlining, that sets up certain locations where people can live and work and that might be in places where there's industry, for example, or substandard housing or all of these sorts of environmental impacts that can impact on health. I think about food deserts. I'm a researcher, and I think about access and availability of quality food that's affordable and accessible for people when racism has set up systems around education and employment that can create limits on upward mobility for people of color.

COVID-19 Pandemic: A recent example of a disparate stressor. Several participants used the example of how the COVID-19 pandemic highlighted structural racism and disadvantages for Black and Brown communities. Loretta says,

> The pandemic disproportionately affected communities of color. I think that that experience of structural racism, living in a still really a colonial imperialist global society has just consistently reduced or completely removed access to resources that are required for communities and societies to thrive and not just survive.

Furthering Loretta's point regarding resources and health, Riley says, "I know that health disparities are rampant; I know that violence is rampant. I know that wealth retention and housing has been historically built to exclude and prevent [Black] people from gaining wealth and success and support."

When considering racism, and, health inequities, specifically the susceptibility to COVID-19 for racialized people, participants contextualized COVID-19 as a crisis that was predictable and saw the devastation in racialized communities as part of a pattern of racism and white supremacy. Remi says,

> Because of racism and how it has impacted, like access to food, and food deserts which again, more folks of color live in because of housing inequities and redlining, we see this with COVID that certain communities, particularly indigenous, Latinx, and black communities have higher rates of diabetes and obesity. I hate that term, but right, like this is the language, the medical system uses. And so, therefore have a higher rate of COVID. Right, but then with the racism of where people are working, they're also more likely to be frontline or service industry workers and so much higher rates [of COVID] and nobody panicked about [COVID] until it was a bunch of like white ladies in their 30s dying.

For many participants, their vantage point of COVID-19 as insiders to healthcare conversations about prevention and intervention strategies, *and* as racial justice advocates emphasized for them how institutionalized racism and white supremacy easily characterized and dismissed health inequities impacting Black people as "individual deficits." Participants conceptualized white supremacy and racism as utilizing a dual foci of individualizing harm while simultaneously systematically suppressing and eliminating group knowledge, survival strategies, histories, cultural legacies, and religions factors typically seen as strengths, sources of resilience, and intrinsic supports from racialized people. Riley points out,

> I think ideologies and religion, have been excluded and diminished and removed from our society based on racism and people have been severed from their culture and their

histories and their sort of ethnic backgrounds, when it comes to places of origin and cultures of origin.

Summing up the perceptions and in agreement with other participants, Riley says, "I think that across the board, the systems, white supremacy and racism requires people of color to navigate systems in a very different way than white people and it requires more energy and stress and thought and anxiety and money and effort across the board." Jonathon points out the far-reaching and detrimental consequences of having safety and strength stripped away from one's racial identity. He adds, "having a sense of belonging 'there,' [in their community, family, tribe] having that then come to be perceived as a risk factor. And then just the way that that impacts people to be seen as a problem, seen as a problem to be solved."

For most participants, the COVID-19 pandemic was a glaring example of the health inequities caused by racism and white supremacy. Many participants had been part of the response to the health crisis and witnessed the disparate impact on Black and Brown families. Participants contextualized the COVID-19 health crisis within the existential threat of *being* for Black and Brown people within a world that threatens the essence of the humanity of Black and Brown lives. The study participants' insights into the far-reaching consequences of COVID-19 and their perceptions of the life-world that predisposes and predicts the disparate health and mortality outcomes for Black and Brown people point to the understanding they take into their racial justice work.

Specific Harms of white Supremacy and Racism to Health. Participants specifically noted their perceptions of the health-related harms of white supremacy and racism. Participants may work (as healthcare providers) in the specific areas mentioned and emphasize these areas because of their healthcare research and practice and the consequential impact of inequities in the

following areas.

Riley points out that despite positive outcomes for a statistically few people, white supremacy and racism impacts Black people in the following areas: mental health, violence, and black maternal health and death in birthing.

> "But we still have a lot of people who have mental health crises, who are committing suicide, who are you know, violent because that's all that they're having to manage and they're having violence like committed against them by the police or by different health care workers, and you know and look at the statistics around black maternal health and maternity and death in birthing for that population."

Rowan says,

> "Structural racism has impacted minority communities, in terms of pollution, access to safe drinking water… We see that every day in our clinic and it has a very tangible impact on you know physical health, and well-being, not even to mention psychological well-being and that kind of chronic trauma of suppression and white supremacy, leading to stress and all the associated negative health outcomes from it."

Other participants identified harms from white supremacy and racism ranging from health inequities in maternal and childbirth, disability, and chronic stress which causes mental and physiological consequences including general life expectancy.

Disability. Remi says,

> I think about when we talk about police violence, black disabled people are the highest number of people killed by the police, not just black people but Black deaf and black disabled people. and so, you know it. … [racism and white supremacy have impacted

racialized people's lives] in accessing disability accommodations and the way that disability has been super racialized.

Chronic stress-trauma response. Participants noted that facing white supremacy and racism daily plays a critical role in the chronicity and increased health problems for people of color. Aiden says, “I think that there's certainly been an increased risk for people of color in terms of their health outcomes, not only because of failings of the healthcare system to treat them equitably, but through the collective trauma that has occurred historically, as well, that has led to physical and psychological changes that are carried forward.” Chloe adds,

> “I think, also over time there's this generational trauma that appears and it's like chronic stress, maybe they didn't experience anything, but their parents or grandmother did and so it's kind of ingrained a little bit to have a higher trauma response and we don't necessarily treat that, just kind of give them, like a high blood pressure medication and we don't really explain it.”

Owen says, “the ways in which centuries of racialized trauma is going to impact the body and impact communities, as resilient as individuals are, there's just only so much that the body can take and then that, manifests in health.” Joyce explains this further,

> “As we think about like cortisol levels, like the stress response, in two situations where a white and a black woman or male might be like completely the same, and there is racism in one encounter and like no racism in the other encounter, just thinking about like being in fight or flight all the time, and what that physiologically does to a person's body, over time.”

Caroline says,

> I think [racism and white supremacy] they've probably shortened [racialized people] they're life, health-wise. I think they have contributed to, not *think*, it's proven, that it's [racism and white supremacy] led to detrimental outcomes for people's health.

Participants' discussion refutes the deficit focused individualization of disorders. Their work or support of the work of Black colleagues in this area contradict years of pseudoscience that denied the impact of racism and white supremacy on the mental and physical health of Black people.

Aiden says,

> I mean so many elements that come into play in terms of affecting health inequities, both the biological ramifications of racism … talking about transgenerational transmission of trauma. That can actually lead to like genetic changes, epigenetic changes. I've been aware of epigenetics for many, many years now and thinking about the ways that trauma, past trauma from prior generations gets passed on in the body as well as in the mind.

Several participants are also engaged in research concerned with epigenetics which according to the participants was initially studied with the children of Holocaust survivors. Tessie says, "the epigenetic work has been done on African American peoples now, too." Tessie explains their perceptions of the significance of epigenetic changes for the health of Black people,

> "An epigenetic inheritance that causes a shortening of the telomeres, you know the caps on the ends of your DNA, such that you would be more likely to live a shorter life, so the statistics we see about African American people having a shorter expected lifespan well that's why. Because they have inherited the trauma of their ancestors…the epigenetic inheritance of centuries of first slavery, then Jim Crow, then you know just the ongoing

systemic structural harm done to Black and Indigenous people of color that has created this epigenetic inheritance of a shortened lifespan."

Mental Health. Charlotte explains that constant discrimination can impact mental health. Charlotte says,

> I work in the field of mental health, and I know it impacts mental health and the way people experience the world of being discriminated against and feelings of needing to prepare every day for discrimination. having to prepare yourself for a world that is against you, and what that means, every day, you have to kind of be ready for that and be ready to be discriminated against in different contexts.

Kyla speaks to the pain of not being accepted for who you are, as a racialized person to have to change who you are to fit into a racist system. Kyla says, "I've witnessed people, have to change their behavior and change who they are to fit into a racist system and to not fully be able to be themselves, which is just a daily trauma, a lifetime of pain."

Mary agreed that racial trauma is unrelenting and occurs daily. Mary says, actually it's sort of an invisible trauma… I think it's a daily trauma that people of color face." Participants like, Mary, who mention the invisibility of the daily racialized trauma get at the far-reaching consequences of racism and white supremacy that are wide-ranging (across life domains), life-long, and often unacknowledged and untreated. Tessie says, "If you have these traumatic experiences in childhood, it increases your likelihood by significant multiple factors of having high blood pressure or of having an addictive like substance use disorder that ends up being life limiting, so I mean it just goes on and on right the systemic effects of these things [racial injustice]."

Physical Health. Tessie says, "when you add to that the harms that begin in the womb

like we talked about with Black women having a greater loss of life in childbirth. Well, you know similar kinds of impacts are happening in terms of fetal well-being." Participants pointed out that the harms to Black women and unborn children in maternal and childbirth go beyond socioeconomic status, medical insurance, and access to healthcare. Remi says, "Black women's maternal health, and this is where right classism doesn't protect, you would think about Serena Williams [famous tennis player] almost dying as a very rich celebrity, and yet, still nothing's changed, even after she shared her story."

Participants saw the threads of white supremacy and racism woven through society, determining how society react to the health crises and respond to the disparate impact of certain illnesses among Black and Brown people. The importance of the contextualization of the perceived specific harms to Black and Brown people within the global harms indicated previously provides salience to the racial justice work the white healthcare providers undertake

Summary of Section One

In Section One: Omnipresence of Racism and White Supremacy, three sub-themes emerged from the data 1) "whiteness/white Supremacy is Visible and Invisible"; 2) "Racism Is"; and 3) "Racialized Trauma." The sub-themes detailed how the participants defined racism, the manifestations of whiteness/white supremacy and the impact of racism and white supremacy on the bodies and psyches of Black and Brown people. The discussion in section one centers on the perpetuity of racism and white supremacy and the constancy of socialization processes that reinforce racism and white supremacy in participants personal and professional lives. This section underscores participants' (in)visible embodiment of race and their ontological reckoning with and experience of the phenomenon of race, racism, and white supremacy from within the social location and positioning of their whiteness. Study participants' acknowledgement of what

they have seen, heard about, researched, or perpetuated (often, despite what they described as best intentions) form the basis of their worldview, and what drives the racial justice work that they choose to participate in. The discussion highlights the social construction of race and the sociopolitical underpinnings that created and systematized a way of oppressing certain bodies and conversely valuing others based on that ideology. Study participants' thoughts and beliefs about racism and white supremacy as a white person existing in a sociopolitical and institutional context that *was* and *is being* built on the denial of racism and white supremacy and ultimately—the denial of the humanity of Black people—provides insight into the racial justice workers' professed affirmation of Black lives *and potentially* the undergirding foundation of their anti-racism behaviors and their perceived need for racial justice work.

Section Two

Theme Two: Anti-Racism (Racial Justice Worker) Identity Development

The second theme Anti-racism (racial justice worker) Identity Development describes the participants perceptions of the process of becoming anti-racist and a "racial justice worker." The theme, Anti-racism (racial justice worker) Identity Development, consisted of three sub-themes 1) Recognizing and Bearing Witness: Reconciling personal convictions of "non-racism;" 2) Intrapersonal Processes for Identifying and Embracing Racial Justice Work; 3) Evolution and Phases of Anti-racism Identity Development. The second theme describes the white healthcare providers' internal and external epistemological battles with *being* in the life world and on the *journey* for racial justice as they embody whiteness and are at times complicit in whiteness. Participants describe how they come to terms with being *always* indicated in white supremacy and racism. Participants under this theme note their progression from individualism to collectivism in anti-racism.

Sub-Theme One: Recognizing and Bearing Witness: Reconciling Personal Convictions of "Non-racism"

Under the theme Anti-racism (racial justice worker) Identity Development, the first sub-theme is Recognizing and Bearing Witness: Reconciling Personal Convictions of "Non-racism;". In the first sub-theme participants described the times that they witnessed white supremacy and racism from their childhood to the daily occurrences that they now recognize as white supremacy and racism. They described what they perceived motivated them and others to participate in racial justice work. Finally, under this sub-theme participants shared their perceptions of their participation in racism and white supremacy.

Witnessing white supremacy and racism. Participants recalled experiences from

childhood to their current work lives where they have witnessed occurrences in which Black people in school, college, church, or work were "othered" and treated differently by those in authority and at times by the participant's family members or work colleagues. Emily notes, "I think we see there's two levels of *seeing* racism there is seeing the interpersonal racism, that individual people experience in that very personal way, and then there's our ability to see larger structures which are set up in a racist way." Loretta agrees and says,

> So that is both, structural racism, allowing a white person to avoid consequences of racist behavior, but that is also the [interpersonal] experiences of a learner and a person of color that should be in a 'safe' learning or working environment being disadvantaged directly because of again identifiable features of belonging to the Black community.

Caroline shared,

> I grew up going to a very much predominantly white church and there was a family who had a number of adopted kids. One of their children probably had like ADD (attention deficit disorder). He was just like really active, but he was always getting in trouble, always getting reprimanded, and he was Black, and it stood out to my noticing, the treatment that he was getting.

Caroline says as a child, she noticed an "othering" that happened with Black boys. Caroline says, "I was in first grade, six or seven [years old] …I think, like around that age was when I came into an understanding of like 'otherness' applied specifically to black boys." Ailene says,

> I also happened to be living in the [south], when I started middle school, when desegregation of schools first occurred in [city], and so I early on I experienced witnessing racism. I saw a lot of what I now know were racist slurs and behaviors, and

> at the time, I didn't understand them exactly. But now, you know now, I get what was going on.

Ailene says,

> Yeah, So I've seen in my work as [names specialty] doctor. I work a lot primarily with young children, with developmental disabilities, particularly autism and their families. And I have seen multiple times when Black mothers in particular were concerned about the ways in which they're autistic little boys were having those [autistic] behaviors attributed to *being* 'Black' boys and 'being aggressive' and 'non-compliant' and you know, having Black mothers talk to me about they [teachers] don't 'understand' that he has autism, and [Black mothers] really feeling that discrimination.

Following up on this, Kevin shares how his Black stepson used to get into "trouble at school all of the time." He shared that he did not believe the incidents were racially motivated until he saw them himself. Kevin says,

> He used to get into trouble at school, and I sort of didn't think it was, you know racially motivated, but when he started going to high school, he figured out how to record things on his phone, and he would bring them home and show us, and it was pretty clear that some of the teachers were pretty racist and doing mean things to him.

Ava says,

> I mean for my whole life I think I've witnessed racism. One instance that comes to mind, I was 27, and I was in class. There were lot of incredibly racially violent things said and done to my classmates over a series of years. And so that's one interpersonal moment of racism that I can think of.

Charlotte remembers the police singling out her Black friend when she was in college. Charlotte says, “My Black friend in our group is who the police kind of targeted to pull to the side, to ask how old he was, what was he doing there. I think at the time I could pick up that there was a reason why, but I don't think I fully understood it, until kind of years later, exactly what was happening at that moment.”

Emily speaks about the racism that she has witnessed within her work setting. Emily shared, “I've seen colleagues of color specifically two black colleagues who have experienced very blatant race racism with like the N word being hurled at them.” Joyce recounts how one of the Black medical school students that she teaches had the police called on her because she was caretaking a friend’s white children and a random person in a store thought it ‘odd’ that three white children were with her.

Joyce says,

> Someone started talking to the kids about like ‘are you okay, like are you supposed to be with this woman,’ ‘are you safe.’ You know, I think, to a certain extent, she [Black medical student] explained that this was her family and like, of course, they were safe.” Despite reassurances from the Black medical school student and the children, Joyce recalls that the person in the store called the police on her student. Joyce relays how ‘upsetting’ and ‘unbelievable’ this was to her and how disheartened and threatened her Black student felt.

Tessie says, “I have been witnessing racism from before I had language for it.” She recalls her father’s racism towards Mexican Americans.

> I saw the way my dad treated people differently based on their racial identity. When I turned 10 years old my dad enforced that racial difference on me and told me I could no

longer play with the neighbor kids. I asked him why, and he said because they're Mexican and you're Anglo and it looks good for them to play with you, but it doesn't look good for you to play with them.

Chloe also remembers hearing her father say racist things. Chloe says, “You know, my father always kind of made off handed slightly racist comments about people he had to work with; to me it always felt wrong, but you don't kind of question your father when you're growing up. Jacob says,

> “I think I witness racism almost every day. I mean it's a long story, because you know it gets into like, ‘how did I become so interested in racism and motivated to work against racism and white supremacy?’ I noticed racism in talking to white people, family, friends and ‘how they think,’ ‘how they make assumptions about people,’ ‘who they socialize with.’”

Kevin shares his personal reflections of “recognizing the devastating role of white supremacy and racism,” against Black people. Kevin shares, “So, really, when you think about it, it doesn't take a whole lot of brain power to realize there's a big discrepancy and big hurdles, between white and Black people.” Kevin shares that Black people statistically represent higher numbers across all negative outcomes (e.g., incarceration, academic achievement) and lower numbers across positive outcomes (e.g., wealth accumulation, home ownership). Kevin says,

> These statistics are not hidden or invisible. The more you think about it, the more obvious it gets. So, it's pretty clear, that there's a huge discrepancy in prisons, in incarceration rates for Black people versus white people and why would that be? There's a big difference in financial aspects you know [Black people’s] their wealth, versus white people. And again, why would that be?

Riley shares,

> I present, often with Dr [S], who is a Black woman in [specialty] as well and I've seen both of us get very different responses to very similar statements, when we are presenting together. I've seen people push back a lot on her more than with me as a white cis-male, sort of giving the same presentation and ideas. I've seen people question or ask sort of inappropriately directed questions to her that they never asked to me.

Remi shares witnessing "people considering doctors of color particularly Black women who are doctors (I mean physicians) to be less competent. Or you know, asked to get a second opinion, that they wouldn't have if their medical provider was white." Remi identifies a pattern of stereotyping and denigrating of the Black professionals with whom they work. Remi says, "Black colleagues getting evaluations back and being told they're not as 'professional' or students saying that their [Black] professor got 'too angry' and 'loud' in the classroom." Liam shares, "I have seen that there are racist promotion practices. You know I've worked in places where there have been phenomenal candidates for leadership roles, who have been non-white, who I think had been looked over for white colleagues."

Participants noticed seeing racism as an on-going occurrence (sometimes) notably located outside themselves. Participants' descriptions of their experiences contextualize them within a white supremacist system as white racial justice workers. Yet, participants also implicated themselves as enacting white supremacy and racism whether through coloniality or distancing from Blackness.

Jonathon recalls realizing he and his team were engaging in white supremacist practices. He adds,

> I was working in a community in [names region] in which there is a large Indigenous population. When the group that was entering the community to provide leadership development came in, they were confronted by members of the native community who said, 'we are feeling very 'othered' by this process. You have not consulted with us about what we wanted or needed in this process, and this is a very colonialist approach to the work that you're doing, we have models of leadership in our community.'

Aiden shares an experience with his grandmother's anti-Black racism. Despite his assurances that the Middle Eastern Indian lady that he was dating was not 'Black,' Aiden's grandmother saw her as Black. Aiden says, "I remember my grandmother, my grandmother asked me, if I was still dating a 'Black' girl. When this was the Indian woman, that I was dating. I kept trying to explain to her, you know she was not 'Black.' But it was like, she couldn't see her as anything other than [Black]."

The Impact of witnessing white supremacy and racism. Participants described how they made sense of the racism and white supremacy that they witnessed. They describe the emotional turmoil that it caused for them. In some cases, participants described how this shaped their resolve for their anti-racism efforts. Jonathon describes the realization that his "interventions" were perpetuating white supremacist practices. He says,

> Well, it has caused me to do a lot of soul searching about the role that I play in the system that perpetuates this kind of intervention work, going into communities, often without being asked, or at least without being thoughtful about how the work has been conceived and likely to be received."

Tessie discusses her dad's edict that she could not play with her Mexican American friends. Tessie says,

> So not knowing what to say to that, I, at that point since it was enculturated in me to go along with it, to participate in it. And you know when you become guilty of something before you have even chosen to participate in it, before you've even become a thinking, really logically thinking, cognitively full-grown person, it does something to you that makes it really hard to wake up, and to become a person who can choose to be different. It takes greater and greater effort, because of what you feel like you're already guilty of. You're already embedded in a system that's so much bigger than you as an individual person.

As participants discussed having witnessed racism and white supremacy. They also describe their frustration with the enactment of whiteness—the ongoing contextualization of themselves within white supremacy. Most participants struggled when they realized that their actions perpetuated the white supremacy that they were trying to work against.

Like Tessie, participants discussed a sense of frustration, anger, feelings of disempowerment, and sadness when their anti-racism efforts do not produce change in racist practices. Loretta describes unsuccessful attempts trying to help her Black student mentee navigate a white professional colleague's racism. Loretta mentions that despite all the reporting mechanisms in place their colleague was able to continue the racist behavior without consequences. After reporting the misconduct of her white colleague and no action was taken to hold this person accountable. Lorretta says, "So yeah, it was disempowering to not make progress. It makes me feel disappointed, disempowered, disheartened, at times, hopeless. But other times more anger." Several other participants endorsed these feelings of anger and sadness. Riley says,

> "I get angry, and I want people to understand, and I get confused, and I just, I get sad as well, I think that that comes later, probably. But sort of a sadness of, 'you've missed it, you've missed the point, you've missed humanity, you've missed justice.' So, I think that that sadness, probably should start first, and coat my action, a little bit more to hopefully make me a little bit more compassionate in my honesty in some instances."

Tessie says,

> I'm going to try to remain professional, uh it makes me, it fills me with rage, honestly it fills me with rage, and it has enraged me for a very long time, and rage will poison you, and kill you, if you don't do something with it. But I understand it, that rage, is energy to do something with, and what I do is the organizing and the teaching, and I take all the action I can take. I use that rage as energy and take action.

Jacob says, "Yeah it always upsets me, and it viscerally affects me and makes me sad. It makes me angry. At times, I feel helpless because of the enormity of it." Like Jacob, Amelia feels the enormity of white supremacy and racism. Amelia says,

> So, discomfort is a big piece of that, I think that certainly disappointment, and sadness, and anger, frustration become another part of that and maybe a feeling of [being] overwhelmed as well about how one changes systems and structures that feel so big.

Amelia also discusses sitting with the dissonance of knowing that white supremacy is benefitting her. Amelia says, "But I think it's kind of a mix of both I'm frustrated and deeply saddened that this is the way it is, and I would like to change it, and also I feel uncomfortable to be a person who's sitting with a system that benefits me." Ava discusses realizing of how pervasive racism is and recognizing that she had to figure out ways to disrupt white supremacy and racism. Ava says,

> I think I had the concept in my head that you know a classroom would be a place where people would put a stop to interpersonal racism and realizing that the systems were so deeply entrenched in our society, and that systems of power are so important to white folks in maintaining those systems of power was really eye-opening for me."

Jacob says, "You know there's this book, *The Racial Contract* by Charles Mills where he says, you know that one of the insidious aspects of racism is not only did white people benefit from it, but it was rendered invisible to them." Jacob's discussion about the "invisibility of racism" is picked up by Ava and Emily. As Ava discussed learning about how pervasive white supremacy and racism is, Emily says that she had to teach herself to look for white supremacy and racism. Emily says,

> I've noticed as a white person it's taken me some time to foster the lens of seeing the structural racism more clearly. I've had to teach myself to look for that and notice that. Because I'm so imbued in whiteness having grown up in whiteness and accepting a certain thing is the norm and assuming that no one, no system would be set up to disadvantage other people.

Liza also mentioned how "seeing" racism impacted her,

> "Oh, my goodness, I felt overwhelmed, I felt enraged, I felt really helpless. I felt incredibly guilty. I felt like I could see in all of those things that I'm now calling racist; I could see myself in those things. I think, maybe not now, but maybe five or six years ago.

Jonathon shared, [witnessing racism] "it has caused me to think about white fragility and how my response is an example of that, and what it means to be vulnerable, to be engaged, to be accountable. So, it's raised a lot of questions for me."

Loretta notes, “I think it's not for everybody, but witnessing injustice, being empathic in a way that you are able to look at harm and trauma without making it about you.” Chloe like other participants noted that the “visibility” of racism changed them. Chloe noted, “exposure having it be in front of them so that they cannot look away.”

Participants noted that it was in the “seeing” and “not being able to look away” and resisting the reflex to make it about themselves that they were able to see a path forward toward anti-racism. The cognitive dissonance that participants experienced when witnessing or enacting racism and white supremacy and having to come to terms with the disruption of their innocence and goodness in a system of ongoing white supremacy and racism. Participants also discussed encountering a sense of anger, frustration, and sadness when their whiteness proved powerless, and their efforts were subdued by the power of white supremacy. The discussion presents participants’ awakening to racism/white supremacy and the sticking points on the journey to becoming comfortable with the discomfort of being implicated in racism and white supremacy. The participants describe how they moved from bearing witness to racism, resisting the urge to look away, to eventually recognizing how their actions or “non-racism” contributed to racism. The discussion also describes what they perceived motivated them and others to participate in racial justice work.

Sub-Theme Two: Intrapersonal Processes for Identifying and Embracing Racial Justice Work

The second sub-theme under the theme Anti-racism (racial justice worker) Identity Development is Intrapersonal Process for Embracing an Anti-Racism Identity. Under this sub-theme some participants described their process of embracing anti-racism as a “journey,” “a lot of thinking,” and “unlearning.” Emily discusses her process of coming to see herself, her actions, and her beliefs that were “imbued in whiteness.”

Emily says, “I’ve had to unlearn that [white supremacy and racism] so I think…you know the awakening with that is troubling. And it can be, I think, for a lot of white people that I work with, they just shut down. Because they don't know what to do with that.” Participants noted that being confronted with white supremacy and racism often caused a myriad of reactions, “guilt,” “sadness,” “anger,” “defensiveness,” and “attempts to equate their oppression with the experiences of those harmed by white supremacy and racism.” Jacob says,

> One of the things I’ve noticed is sometimes white students who've had experiences of discrimination based on some aspects of their social identities, like being queer or transgender can sometimes draw on that to get a better sense of what it feels like to be oppressed by basis of that, by virtue of who you are in your social identity. But there's always a risk with that, which is, I sometimes have white students who say, well, you know I’m oppressed too, because I’m queer. And it's not the same, and so it's a subtle dance. I think that, but that can be an entry point, I guess, I would say.

Other participants also described how they have seen people, from family members to work colleagues, who when confronted with their role in white supremacy and racism “shut down.” Remi noted that, “guilt or shame, I am going to put that first. I think that’s where people start.” Amelia says,

> “The guilt. I tried to see that, for what it is, I guess in my own self to call like that's white guilt or that's white fragility or that's not wanting to be called out for doing something wrong, you know I think there's that fragility piece that I think it's true for me and also something I feel like I’m hopefully seeing for what that is.”

Recognizing the humanity of “Othered” people and Claiming Humanity as a white Person. Jacob says, “[It] is a higher moral vision, where racism is not, it could be a spiritual

vision, where racism is not part of that vision, and whether it's like being a member of a religious group, or an ethical society, or you know where there is transcendent ethical values. So that would be one thing I can think of."

Tessie says,

> I think it's important for white people to be involved in racial justice work, because that is, work that, we must have, to reclaim our full humanity. I think when we see and know the truth about how our society and our communities function or failed to function, that we can't help but, I hope that, we can't help but participate.

Participants identified that moving past the "guilt and shame," and not "getting stuck" often involved a recognition of the humanity of people impacted by white supremacy and racism and the systemic harms perpetuated by white supremacy and racism. Participants recognition of the "humanity" counters the intention of white supremacy and racism which is to *de*humanize and depersonalize the suffering of racialized people. Jacob points out,

> And the other thing that comes to mind is personalizing, not just abstracting, but thinking about people you care about, and thinking about the impact of racism on their lives and to try to project oneself into situations if one's white, about what it would be like, for you, for your kids…try and deepen the empathy through some kind of personal connection.

Kevin perceived that for people to start on a journey of anti-racism they have to become "upset about the injustice." He goes on to say,

> You know [racial injustice] it's just not fair, right, and some [white people] probably have had specific examples, or they've seen some bad racism, you know, in their face, and that really bothered them. And some people may be just empathetic for people who are getting screwed over.

Tessie agrees, “it's I guess it's an expression of if you see the truth, if you allow yourself to take in the truth. It will set you free. But first you have to work hard to change how things are.” Owen adds, “humanity permeates through and engenders the desire to change things.” Jacob says, “I think loyalty to humanity necessitates racial justice work.” Participants noted that white supremacy and racism support other social ills and harms to humanity. Jacob says,

> I don't want to live in a world where you know, like racism again, it can involve everyday racism, structural racism, but it also allows genocide and involves armed conflict. I don't want to live in a world where that is the norm, and I feel like that is something I viscerally respond to, and I really want to do whatever I can, and I know that you know all of us have to do something together and it all adds up.

Participants identified feeling “a calling,” “a push,” “a drive,” to commit to racial justice work. Amelia says,

> “like a push to say this is wrong. This is wrong, I see the way in which this plays out, I see the harm that this has caused from my social work lens also certainly for my personal lens and a desire to change systems, because we have to, like because [racism] it's incredibly harmful and there's no reason not to.”

Some participants noted that they were exposed to anti-racism by their parents and for some their racial justice work seemed a natural extension of what they had been taught. Kevin identified as Jewish and shared growing up hearing his father’s experiences of antisemitism.

> My dad would tell us a lot of different stories about racism, and this was racism against Jews. He told us how he would get beat up at school because he was Jewish. People would actually say to him, this was in Canada, they would say, ‘Wait, until Hitler gets

> you,' which was sort of very odd, because many of these people probably had relatives who were fighting the war against Hitler.

Jacob noted that,

> Okay, this is where it gets more complicated, so I grew up in a liberal Jewish family in New York City and my parents were very much overtly against racism. In fact, one of my father's students was one of the three people who were murdered in Mississippi [during civil rights era] and I remember when he came back and was devastated and was talking about the impact that this had on him.

In contrast, Mary says, "My parents never talked to me about race and part of that was the time [period]." She became motivated to teach her children about race, racism, and anti-racism because she felt there was so much that she didn't learn while growing up. She says,

> I think part of that is my willingness to take off my blinders. I think as a white person, I have to consciously think about race. I have to consciously *choose* to think about it. I think having kids has been part of that, it's like I don't want my kids to have to unlearn racism. I want them to grow up anti-racist.

Participants describe an awakening of their racial consciousness that denies them the ability to turn their blinders off in terms of racism and white supremacy. Yet, they experience the dissonance of "never" fully *arriving* at racial justice. Participants acknowledge that they commit racist acts or take part in white supremacist cultures and must continuously challenge themselves.

Propelled Along an Anti-racism Journey. Emily says, "I'm finding that, or I have found since I started doing this kind of work, which started roughly 30 years ago, but [racial justice work] it's always a work in progress. I have, I have gotten to the place where I am

consistently doing it, even with the pain of it." As Emily notes the "pain of it," Jacob noted that he began to note areas of opportunity for growth in his anti-racism identity beyond the lessons learned from his parents. Jacob says,

> But then I went to another phase, when I realized that my parents had lots of biases, that they had never examined their privileges. That they assumed as Jews that they understood oppression, but they didn't, in my view, compared to what people of color experienced in this world right, in this society.

Other participants recalled significant moments in their life that prompted their involvement in racial justice work. Caroline recalls growing up in

> a predominantly white, [although] not exclusively, you know university town. But I remember walking on the street, and there were two kids, two black boys, who are the same age as me. I think we were like classmates, walking probably like a block behind me on the street, I think we're both carrying like bags brown paper bags from a bagel store. And I remember very vividly the COP car, just like making a u turn and going back to the guys behind me who were doing the exact same thing that I was doing, which was walking and carrying a brown paper bag.

Caroline remembered thinking "they just got racially profiled." Caroline recalls that she has benefited from being around Black people who "felt free to just speak freely" about racism. Caroline also recalled learning a lot from a Black professor who helped "open her eyes to social justice." Like Caroline, Ava remembers the significant role her Black professor played in her anti-racism identity development. Ava says, "It's a Black professor and she really helped shape my understanding of everything, really."

Whereas other participants noted that their encounters with their medical school or graduate students really opened their eyes and propelled their anti-racism journey. Ailene says, "I really think that the thing that prompted me most was those two black women students when Trump was being elected, saying, they were worried. That like hit me like a ton of bricks." Charlotte notes that it is the influence of her Black colleagues that helps her to develop her anti-racism identity. Charlotte says,

> It's my black colleagues really being willing to share, about their personal experiences and driving home kind of how critical these things are and their willingness to kind of bring me in as an ally and let me make mistakes and let me learn from them and, and I would say that was the big shift for me.

Liam says,

> …I think that certainly the events of 2020 [COVID-19 disparities and public murder of George Floyd by police officer]. I think increased the intensity of our engagement. Just all of the awful things that continue to occur in terms of police brutality towards Black people in this country.

Participants note that seeing racist incidents and systemic racism intensified their engagement in anti-racism work. Participants also contextualize the meaning-making they employ to understand their role in racial justice work as a process that is supported and challenged by Black people and others who challenge racism. Participants' perceptions of their life-world as the evolving ability to see themselves and others' professed anti-racism affords them opportunities for growth in their anti-racism efforts.

Sub-Theme Three: Evolution and Phases of Anti-racism Identity Development

Under the theme Anti-racism (racial justice worker) Identity Development sub-theme three, Evolution and Phases of Anti-racism Identity Development, participants share their process of evolving and growing their anti-racism identity. Participants described the evolution of an anti-racism identity and identified this as "an ongoing process" of development, reflexivity, and action. Participants described that they and other racial justice workers evolved through three phases of anti-racism identity development 1) Awareness and Benevolence 2) Seeking Relationship 3) Community and Coalition Building. The following section outlines participants' discussion around these phases.

Phase 1 of Anti-racism identity development: Awareness and Benevolence. Participants described beginning their anti-racism journey with the awareness that "racism still exists." Rowan says,

> Well, I'd say, for one, it was a bit of a wake-up call to see it so out in the open like that, you know. I think we get a lot of kind of training or kind of programming in school almost to think that we live in a in a post racial world or that you know after Martin Luther King, oh, you know everything is fine and seeing it directly it really prompted me to think oh my gosh, like no, [racism] this is like absolutely just as much as a problem as it's ever been.

Participants described this first phase as "breaking through" and "taking blinders off." Kevin discusses his coming to terms with his complicity and his disillusionment with "DEI" [diversity, equity, and inclusion] groups at his hospital. Kevin says,

> Well, it's hard; right, because like I said, if you don't say anything, you're complicit. And so, to a degree, I guess I've been complicit in a lot of situations, and you know I haven't made a big fuss ever or made a big fight. That's what you also see with this DEI group,

> you know they have their meetings, but they don't make a big fight about anything, which is probably why it's ineffective.

Aiden says, "being a white person myself, it can be hard to see, because I'm sitting in it. But I'm trying to see." Liam feels like recent events have been an eye-opener to racism for some white people. Liam says, "I think that many white people now are getting more and more switched on to the existence of acknowledging the reality of racism and white supremacy and the fact that racism and racist policies and racist systems still exist." Ailene mentions before recent events not *having* to think of racism and white supremacy and being able to justify that "everything is better". Ailene says,

> And it's you know until probably right leading up to 2020, it was easy to not think about it. In the years since the bulk of the civil rights movement, and Martin Luther King, I think that in those, you know, 40, whatever years, I think it's been easy for white people to think, 'Oh, well you know, the civil rights movement happened. Everything's getting better. I don't really have to think about this [racism or white supremacy].' I think that that's unfortunate.

Liza says,

> you know, I was that, you know, the white moderate that Dr King talked about, you know, the most dangerous for progress and dismantling injustice and that was, that was totally me and I'm glad that I can see that, for what it is, but there was really a huge feeling of rage and also helplessness and guilt with that.

Jacob says,

> I feel like that's often the kind of racism I'm noticing, which is the kind that where white people think I'm a good person, I'm doing good stuff, my intentions are good, I don't

have prejudices and yet they are living lives and embodying aspects of racism that are manifested through micro aggressions, through stereotypes, through aversive racism, through segregation. I could go on, but I mean, I'll stop there.

Participants described their complicity with white supremacy and racism, their incrementalist approach to change, and their *good benevolent* helper mentality that kept them situated in whiteness. Participants also noted that often in this phase of the anti-racism identity development racial justice efforts can be misguided and initiate from a place of white saviorism and acts of benevolence like charitable giving.

Riley says,

> "So, I would say, the general white person, we want to think about like population and numbers wise, I think starts, often with charity, unfortunately, I think that white saviorism is definitely a first stepping stone for so many white people, and it's almost like the very wrong first stepping stone. But it's often the way that so many white people get exposed to some of the things that would challenge them out of that position."

Amelia says,

> I feel like when I was learning about [what] social work was and being trained as a social worker, this is no one's fault, it was what people knew at the time. I don't think there was a lot of discussion, I was involved in about white saviorism. [white saviorism] is something that came to me later in my career, and definitely hit home with like, oh wow, how much of that is what motivates me and what motivates a lot of other white folks that are especially in sort of helping professions?

Participants also noted that white saviorism and the "charity model" are based on white supremacy. Chloe says,

> “I think there's a lot of unconscious white supremacy and white saviorism that I’m still probably not acknowledging. I think my interest in helping people probably spouted from white saviorism with my mother talking about how she felt bad for ‘black and brown babies’ in that hospital.

Riley says, “But charity and white saviorism, I would say is probably one of the biggest motivations which is still coming from white supremacy and still coming from a history of racialization of charity.” Participants also noted that white people may be motivated to start benevolent actions by feelings of guilt but can get stuck in a place of “guilt” and have difficulty reconciling the feelings of guilt and transitioning to anti-racism action.

Remi says,

> Like the very traditional white guilt shame model of like oh, how can I say I’m doing anti-racist work, how can I say I’m doing racial justice work if this person told me that I said the wrong thing … I’m not meant to do it, like that's the reaction of like the ‘flounce out of racial justice spaces,’ because you got called in, is just as harmful as never going to a racial justice space.

Charlotte says,

> I think guilt, or feelings, of yeah, like guilt, I think motivates some people. Right, like if you learn about these things, and you really internalize what it means that. I have access to something, or I don't have to worry about something, because of nothing I did, but just because of the color of my skin and the way the country that I live in operates.

Liam says,

> I don't know if it [racial justice work] has necessarily impacted my sense of self. I think there's a constant sense of this [racial justice work], you know, is this the right thing to

> do; is this enough? There's a lot of guilt; I often feel like, the more I do, the more guilty I feel, because the greater I realize the problems, the deeper, I delve the more you see, the more you realize that needs to be done.

Riley agrees, adding,

> I would say it is guilt. I think that they often are, once they do learn and they get past that sort of white saviorism and white sort of charity phase, they start seeing the realities of what our system and society has done, and they start feeling really guilty about who they are. And what they have benefited from, and so they want to be giving back and it still ends up being a little bit of a charity model in those instances.

Participants noted that in this phase white people's efforts for anti-racism may be designed to make them feel better about themselves or demonstrate how "good" they are. Charlotte says, "maybe some people engage in the work, because it makes them reduce that guilt right like they get some sort of positive, like, 'oh I'm doing such a good thing.'" Liza noted the performative quality of the anti-racism work, "I also think that you know, sometimes people say they're involved in racial justice work and it's more performative, and you know it's more like for them, than for racial justice." Participants also note that evolution of the anti-racism identity in this phase of development must include self-reflection. Liza discusses her journey after she realizes "I am that person" and that her "anti-racism" efforts were performative and harmful. Liza says,

> I read books and I think what really kind of drove me into that kind of path of seeing it [my own personal racism] was several years prior you know when we had the race and social justice initiative that was well intended and awful and just seeing the way that it hurt [people of color] and my part in that, really kind of propelled me forward.

Participants noted that moving through this phase of their anti-racism identity involved awareness and constant self-reflection. They shared constantly evolving their ideas about how they engaged in racial justice work and how they saw themselves and their social location.

Phase 2 of Anti-racism Identity Development: Seeking Relationship. Participants described the second phase of an evolving anti-racism identity as locating one's relationship with the temporal and spatial manifestation of white supremacy and racism (how racism manifested/manifests across space and time) and fostering cross racial relationships (communication, compromise, and commitment). Participants discussed "unlearning" and locating themselves in society. Liza says, "Depending on the person I mean, I think it affects us differently, but, as you know, as a society, I think that it has really destroyed like the best parts of us and made it okay, and justified it, and reinforced it, and used science to back it up." Remi says, "And so yeah, I'd say racism and white supremacy impact white people by authenticity in relationships, a lack of understanding of ourselves, our history, our ancestors, this idea that like white people don't have ancestors is bull**** we all have ancestors right."

Participants noted after they "dislocation" and disconnection that they had been taught by white supremacy. The history of white supremacy across the world was disconnected from them as individuals always in an ongoing space outside of their bodies. After locating their relationship with white supremacy, coming to terms with and understanding their relationship to the temporal and spatial manifestation of white supremacy and racism was very important. Aiden says,

> And I know along the way for me, at least, it's been grappling with like family history and personal history and thinking about ways that I might be able to dismantle. Like not look away from my past history and my family history but be able to see it for what it is,

> be able to name it, and be able to say I can make a change in terms of a legacy with moving forward.

Participants also noted through self-reflection beginning to understand their positionality and how their identities interacted and were in relationship with white supremacy and racism through the privilege or oppression of their identities. Emily says,

> So just to start this, the social identities that I have; I am white and identify as a cisgender woman. I'm straight, I'm disabled, and I think those are really salient ones. You know, being a white kid from a privileged suburb and watching the busing got me going, that's my first recollection of whiteness. But it took me a long time to really see how the privilege played out, and how I behaved and acted and thought. So, my whiteness is a huge piece of my wanting to be part of something better for people.

Owen says,

> I mean you know there's lots of debate about that, or whatever that people have different feelings. But I guess my point in saying that is yeah, right I need to not only hold this in, [but also] I need to be active, and to use all of these things that white men have done to damage everything so much. What if I use them to do the opposite? What if I'm a loud, obnoxious voice for the opposite?... There is something [about] that when white people but, and, especially white cis[gender] men get up here and start naming what's happening.

Kyla says,

> Well, I mean the obvious one of being a white woman, certainly shape my experiences with racial justice work; and like, I said, I realized it's something I don't *have* to think about because of my privilege. It is like 'oh, well I could close my eyes to this,' like it's

> so terrible to think that. But people do, and so that's certainly shaped my commitment to racial justice.

Tessie says,

> I can say that even though I would describe myself, as a mother and a feminist and a queer person, that none of those are as primary in terms of how I understand my day to day like motivation and direction and what I'm trying to accomplish in terms of my agency and my volition in my life. My anti-racist identity shapes more of who I am and what I do than any other aspect of my identity.

Participants in this phase of their anti-racism identity development were able to see both how their identities have perpetuated racism and white supremacy across space and time and to see their "whiteness" as a part of their reason for involvement in racial justice work. For instance, just as Kyla named being a white woman as shaping her experience with racial justice work, participants named white femininity as a vehicle that empowers racism and undergirds white supremacy and that their identity as white women have been used historically to weaponize racism and white supremacy. As Jacob mentioned earlier on in the chapter, Remi noted how they struggled with racial justice work because they started their journey believing that the oppression, they experienced based on their marginalized identities, was not acknowledged in the same way as racism and white supremacy. They felt becoming so caught up in attempts to "level their oppression with racism and white supremacy" harmed their racial justice work. Remi says,

> I think originally [my social identity] it was more harmful to the work I was trying to do, because I was caught up in the 'but look at all my marginalization;' and, like, yeah that sucks, you know, and I used a lot of 'butts' instead of 'ands.' Yeah, I experienced

> marginalization, this way, and it's *not* racism, and it's *not* white supremacy and so let's talk about like what that looks like.

Along with feeling the need to assert their oppressed identities, for some participants, the complexity of finding power for themselves was at war with alienating white men and white family members. Remi thinks that white women have to grapple with "which side to be on." Remi says,

> So, I think those are some ways, I think white women are in a particularly complicated spot with racism. It puts us in a position that in order to get any power …We have to decide whether we are on the side of white men or if we're on the side of our siblings of color. I think about like the p**** March, the march on Washington. It was a bunch of white cis-women, you know talking about what it meant for them specifically because, for them to get what they wanted they had to throw people of color under the bus.

Some participants used their positionality to help them empathize with those experiencing white supremacy and racism. Ailene says,

> How those things [successes] have come to me because of the identities that I hold and being able to sort of reflect on that and then contrast that with people or just imagining someone else in my situation, who, you know one or more about those identities was different, especially something like, having dark skin. You can't hide that. I mean I think that's the main thing that is really making me more humble in terms of like I didn't get where I am, just because, like I'm a great person. Part of why I got where I am is because of all those identities I've come with. And you know that can be really humbling, and it just makes me then, in contrast, so much more aware of inequities and injustices.

Joyce says,

> I identify as a white woman and also as an educator and a caregiver. You know, being a woman and thinking about like how there are like situations where I feel like, I guess not oppressed, but like where I'm at some sort of disadvantage as a woman and then just realizing like, whoa there, you know people who are like oppressed because of racism, like my feeling of like whatever disadvantage, I have as a [white] woman in a situation like I have to really check myself and remember that it's nothing compared to what my peers and my patients and like what people of color you know are up against in like what is a truly racist society.

Participants in this phase of anti-racism identity development began to see how white supremacy and racism have taken away their "sense of connection" and "robbed them of their humanity." They see their lack of relationships with Black and other people of color as part of the costs of white supremacy and racism. Amelia says,

> the racism and white supremacy is so big and baked into how we are also taught to navigate the world and talk, and be, and be blind to the privilege that has been given to us, but I also think [racism and white supremacy] can disconnects us from people, because we are walking around without a realization of the harm that we may be creating and doing or the harm that's being done.

Jacob says,

> I think there's study after study that shows how people empathize with people who they think are "like them", and I think that white people, therefore, are not fully human because of racism. I feel like [racism] it gets in the way of seeing oneself, as a member of a world community of all races and ethnicities and one of equity, that does not elevate or prioritize one group over another. I think white people have a lot of trouble with that

> because I think they've been so saturated with white privilege and white supremacy that it [racism and white supremacy] just seems normal to them.

Tessie explains it is not just having a relationship with another human being but understanding our relationship to history and its impact on the future. Tessie says,

> So, understanding that relationship of how did what we did do, create what we have now, and how do we need to change what we have now? So, we don't get stuck with it, so that we can change what we will have in the future.

Relationships with Black people and Other People of Color: Seeing Humanity.

Participants in this phase of anti-racism identity development also saw the benefit of fostering cross racial relationships and the opportunities they offered for growth. They began to seek relationships with Black or other people of color. Caroline recalls that she has benefited from being around Black people who "felt free to just speak freely" about racism. Caroline also recalled learning a lot from a Black professor who helped "open her eyes to social justice." Like Caroline, Ava remembers the significant role her Black professor played in her anti-racism identity development. Ava says, "It's a Black professor and she really helped shape my understanding of everything, really."

Whereas other participants noted that their encounters with their Black medical school or graduate students or Black colleagues that opened their eyes and propelled their anti-racism journey. Ailene says, "I really think that the thing that prompted me most was those two black women students when Trump was being elected, saying, they were worried. That like hit me like a ton of bricks." Charlotte notes that it is the influence of her Black colleagues that helps her to develop her anti-racism identity. Charlotte says, "It's my black colleagues really being willing to share, about their personal experiences and driving home kind of how critical these things are

and their willingness to kind of bring me in as an ally and let me make mistakes and let me learn from them and, and I would say that was the big shift for me."

Participants noted that seeing racist incidents and systemic racism intensified their engagement in anti-racism work. Liam says,

> …I think that certainly the events of 2020 [COVID-19 disparities and public murder of George Floyd by police officer]. I think increased the intensity of our engagement. Just all of the awful things that continue to occur in terms of police brutality towards Black people in this country.

As Jacob indicated earlier, participants in this phase of anti-racism identity development began to view their humanity in relationship to the humanity of Black or other people of color. They began to care what happened to the Black and other people of color with whom they had relationships.

Remi says,

> I don't want people I care about to come to harm, and I think most people are the same way right, and so like once people get through that guilt or shame, and also get through that rose colored [hope] and maybe still they have some that rose colored hope. I think they're like, I need to do better for my people, and I need to do better for my community and so it is in relation or in community that people join this work.

Ailene says,

> And I'm not going to say I've been one of the people thinking deeply about it all along, but it has always been on my radar as a source of inequity, because I grew up understanding that from my parents. But you know honestly, until Donald Trump started running for president, I didn't think about it as hard as I have been since then, and part of

> that was because I had students [medical specialty] in my classroom who are African American, who were worried about what was going to happen to them if Trump was elected President. And that just like was eye-opening. Still, I just like have to say it, like that just blew me away, that they like had to say that out loud. And I thought, Yeah, no, we need to not do this.

Jonathon says, "I can't say that I feel, you know, in some way better or stronger. It doesn't feel like I am a better person for having engaged in this work. I think most often, I feel like it's just so much more I could do, there's so much more I should do." Mary discusses coming to realize race and racism impacts every aspect of life from the books she chooses at the library.

> I think it impacts the conversations that I have with my kids. [My husband] is a [names profession] …you know I'll I talk with him about you know how race plays a role in things that are happening in his trials or different situations that arise with at work. I mean it impacts the books that we're reading that [are available] at the library.

Participants note, that as white people move along the anti-racism identity development journey, the process of being receptive to learn how to confront their complicity and assuming a willingness to learn becomes most important. Remi recalls an incident in which someone points out her actions and her overcoming the urge to become defensive and disengaging the anti-racism work. Remi says,

> Okay, this is not her saying, she doesn't value me as a person, this is not her saying I'm a bad person. This is her saying that, like the way I went about this, was like a little bit of white savior, a little bit of white martyr, and what worked for my mentor because she and I have a relationship that looks different and like she, maybe, understood my intention, even if the words were not the right ones….Right, so I apologize, I was like 'you're right,

I apologize for making that, you know, assumption of labor on your behalf, and I will do that work.’ Then we can keep doing work in community.

Riley says, “So, finding, I think, trust is such an important part of racial justice work and trusting not only that racialized folks and the folks of color I work with see me as trustworthy, but see me as someone that they can give feedback to and that I’m not going to flounce.”

Mary says,

> One thing is just people's individual like racialized journeys. I think, and kind of white people be willing to… I mean it's a devastating thing to be part of this huge problem, and being able to recognize that, acknowledge it: And, then like, instead of getting angry and defensive about it, try to do something about it, I guess. That's a really important component of racial justice work from white people.

Joyce says,

> You know it's a shame, I went through 30 years of my life like not really understanding the experience of others [people of color] and I don't I still don't claim to understand what it's like to you know go through life being you know opposed by racism and I don't understand…. But I think I am just now starting to understand what impact that has on people.

Aiden says,

> I know there's lots of opportunities for continued growth and learning that are there for me, I certainly don't have it all figured out, but I think I’m on the right side of history with this, and on the right side of what it means to be a human with other humans.

Like Aiden, Kyla sees this journey as a continual learning process, and she describes the enhanced sense of integrity and authenticity that she feels. Kyla says,

> So I feel like [by being involved in racial justice work] you're gaining this sense of being truer, to ourselves, as like, I'm gaining more integrity, and who I am as a person, and being truer to my values, and so that helps me to connect with other people better.

Owen says, "[Racial justice work] it's leading me on a path of life that I want to live. Like when I think about that true happiness, or whatever that is. I think that [racial justice work] it's so embedded in my identities."

Participants described the second phase of anti-racism identity development as a place of gaining a sense of fulfillment, a sense of integrity and an enhanced sense of self, because of their reflecting, learning, and developing understanding of their temporal and spacial relationship to white supremacy and racism. They also began to seek and grow from relationships with Black and other people of color. Participants in this phase used their personal growth and understanding of their relationship with white supremacy and racism and with Black and other people of color to strengthen their resolve for anti-racism action.

Phase 3 of Anti-racism Identity Development: Community and Coalition Building.

Participants in phase 3 of Anti-racism identity development: Community and coalition building discussed gaining a sense of "being a part of a movement;" "embracing a mission;" "being a part of a coalition;" and "gaining a sense of community with others." Participants described how they used their growth and understanding of themselves in relation to their whiteness and in relationship with others to advance their racial justice work in community with others. Participants discussed their anti-racism identity as being the driving force of their life and how they entered a "coalition" for racial justice work. While for some becoming a part of a coalition, was more of a circuitous path to gain understanding and connection to people of color, Loretta described a life-long connection and fight against injustice. Loretta says,

> I had the benefit of going to schools where folks of color were present and forming friendships with those people very early on and through family experience. I have family members who identify as gay and as trans so getting involved in social justice work around LGBTQ identities, you know changes in legislation, seeing that battle.

Likewise, Joyce says, "I think, in my personal relationships, I gain a deeper understanding and appreciation for what my friends of color go through, have gone through. And that to me leads to better connectedness and more meaningful conversations." Riley says,

> I would say [this phase] is coalition. I think there's a certain point, where a white person understands their connection to the other humans around them, and they understand blackness, they understand it, *as a thing*, not the *experience* of it, but they understand what it means to be looking at race, not being colorblind, but still connecting on a human level like not trying to erase the racialized experience of us all, but to incorporate it into our deep understanding and compassionate connection with the people that we are doing this work with.

Liza says,

> I feel like I see differently, I listen differently, and that has been just unequivocally so important for me. [Racial justice work] it has made me kind of, at the same time, more hopeful and more hopeless because on the one hand sort of seeing the depth of the annihilation that has been caused by white supremacy, but also seeing kind of a critical mass of awareness and conviction, coming about.

Owen says,

> I really learned how to decenter myself. I don't want to say to not I do not make mistakes. I still, make mistakes. But I'm really learning how to decenter myself in this work. It

> actually has nothing to do with me as an individual, like in terms of being a loud voice or being a good white guy, it's not what this work [racial justice work] is about at all. I think yeah, it's just taken me doing that, and that's the thing that for other white folks that I try to talk to who are trying to go through this. My thing is for me it's been an absolute journey that has been ups and downs and bumps and turns and twists to mistakes and all of these things.

Riley says,

> But if you're able to get past those other two phases into a place of coalition building and community building. While also doing some solid self-reflection and positionality work in the process that's where we see I think long standing white allies step into the fold in a more effective and appropriate way and can maintain their work and racial justice work.

Amelia stresses moving past fearing discomfort and welcoming discomfort was essential for her growth and connection in this phase. Amelia says,

> [Racial justice work] It definitely feels like it's made me uncomfortable you know, in a way that I think is really important, and I'm happy to have been made uncomfortable. In some ways that's [feeling "uncomfortable" doing racial justice work] one of the biggest things that sticks out to me, but also coming to deeper understandings of what it really means to understand and support and be connected to people.

Emily says, "To me [racial justice work] it's an assumed at this point. This is part of who I am. This is part of what I'm going to work for to the best of my ability, with an open heart and with an open mind." Ailene says,

> [My racial justice work] I feel like it's, contributed to my sense of wholeness. Like I'm doing something that I not only think needs to be done, but that like feels like also a part

of me. And it's just you know, taking my voice to do that…. So, my sense of self has really been I think enhanced by this, because it has felt right to me, and not comfortable in terms of like it's easy, because it's not, but comfortable in that, like I belong here. I belong in this work. It's not the only place I belong. But I do belong here….

Ailene says,

> So, I feel like the things that I've done in terms of racial justice work have really, I don't know, I feel like I'm a better person, and it's not supposed to be about me. But if I feel like I'm adding habits to my daily life, that support other people's inclusion and equity, then you know that to me is a good thing.

Participants in this phase also noted how an anti-racism identity is not static but involves continuous growth and learning. They shared that people may cycle through learn and relearn lessons and that growth is possible at all levels. Participants in this stage discussed the ongoing process of development, reflexivity, and action. For instance, Loretta describes being a part of a larger coalition of racial justice workers and having to be comfortable with taking risks and practicing humility when their intentions do not match the impact of their actions. She describes incidents when they experienced opportunities for growth. Loretta says,

> But I feel okay with that level of risk, because I do actively practice humility, and I know that if I do say something out of turn, even if it's well intentioned, but is ultimately harmful that I'm willing and able to take responsibility for that harm and make changes. Because that is the goal I'm not out to be like the only expert or be unquestioned.

Participants described the "community" and "coalition" that they created as a place where they can gain perspective and ensure that their motives for the work move beyond white saviorism. Amelia says,

But also, for me, it's meant reaching out to other particularly white folks doing the same work that I am and asking how they're incorporating racial justice work I guess from their perspective as a white person. So, learning more about what those options might be."

Like Amelia, Joyce shared that she tries to learn from others who are involved in racial justice work. She shared that she intentionally chooses to learn from people who are embodying an anti-racism identity and action. Joyce says,

> Trying to learn from the people who are actually doing the work, so like having a good source for the learning that I do. I don't want to learn about white supremacy, from a white supremacist, you know. I want to learn from people who are doing the work in a reputable and meaningful way.

Chloe also shared that she tries to check the motivations behind her actions, she expresses that she has to question if her work is for the "community" or to accomplish her personal goals. Chloe says,

> So that's how I try to resolve some of the white saviorism, and I just wonder if something's actually beneficial for the Community I am serving; or is it just for me to meet the numbers that we need. Sometimes I probably fail at that and don't realize it. You know I always welcome people to tell me anything. If I need to improve anything, and hopefully they do feel that [they can tell me]. But it's probably still hard to isolate those behaviors sometimes because they can be so unconscious.

Participants in this phase, like Chloe and Amelia, shared that sometimes despite their best intentions the impact of their actions perpetuate white supremacy and racism. They shared that they try to safeguard against this by "talking through things" and trying to make sense of it." Amelia says,

> I also think on a professional level or even friends outside of that, I think it's probably a lot of other white people initially that again [I would talk to]. It's the talking things through and making sense of it. And again, to me, the vulnerability of 'I think I did this racist thing, and I want to figure it out. I want to talk it through, and I don't want you to just tell me, it's, okay, or that you know I'm sure they didn't take it that way.'

Participants expressed that seeking feedback and gaining awareness through reading and relationships with Black and other people of color that are harmed by white supremacy and racism was a very important step in checking their actions. Ailene says, "Well, one way I make sure I am not playing into white supremacy or white saviorism is I ask for feedback pretty regularly, from people that I trust to tell me, that is people of color that I'm working with, especially." In racial justice work, Loretta says, "awareness is number one." Riley says,

> But I would say, like those intentional practices, those relationships, those ongoing questionings is sort of my main strategy and education. I'm just like constantly reading, particularly the voices of people of color obviously, who've already done the work to write it down for us to read it, and just really thinking and processing and incorporating those perspectives into my life, hopefully, is the net that catches, some of those actions before they manifest.

Participants also acknowledged the internal conflict of learning how to "check themselves" and "trying not to takeover or take the lead" that they felt is important for white people and comes with being involved in anti-racism work. Charlotte says,

> And I'm just trying to follow some advice from people that just said, like you could just avoid that, all together, by not being involved [in racial justice work]. But then, is that really the right thing to do? Right, you could avoid this worry about being a savior or

> worry about actually doing that, in an instant. If you just aren't involved at all, you don't have to worry about that. But then, you're not doing anything, and that's not you, that doesn't align with your beliefs in yourself. I'm mindful of the sort of white savior complex that can come into play in work around racism, and so I check myself, and I ask my friends of color, as well, to help me check myself to make sure that's not what I'm doing. I'm not trying to get out and lead, when, I should be making way for others instead, and helping use my voice to open doors.

Other participants also describe "trying to not take the lead" or "decentering" themselves in their racial justice efforts. Ava says,

> Yeah, I think about it [how to decenter myself and my whiteness] all the time?And I think again. I think this has been informed by my work with black women. And I'm lucky enough to have black women in my life who will be very candid with me, and just tell me like 'Bro, you're not doing a good job', which is super helpful. Because the only way to do better is to understand when you're messing it up. I think I have messed it up in the past, and that has helped me to understand how to not do it in the future. And I think about it all the time in following other people's lead people specifically who've been harmed, people who have been marginalized or racialized. I think, this is critical in not centering yourself.

Rowan describes reading a book by a Black author, Ta-Nehisi Coates called *Between the World and Me.* Rowan describes being influenced by the author's use of the character Luke Skywalker to portray white saviorism. He shared about interrogating white saviorism to reach effective advocacy in his racial justice work. Rowan says,

> “I don't know, I guess kind of reading that,… how white people are a race of Prince Aragorns or Luke Skywalkers living in their you know, fantasy world in which they're the hero and not unintentional oppressors, that's paraphrase …Luke Skywalker as a representative of a pure white savior, was just a very tangible way of identifying that savior complex and thinking, what is the difference between being a, like a savior, so to speak, and being an effective advocate.”

While Liza says that she must constantly course correct to make sure that she is working as part of the “community” for racial justice and not feeding into white saviorism. Liza says,

> I think white saviorism is something that resonates for me a lot, and I know that I have tendencies that way, it is like almost a continual [acknowledgment]. You know when you're driving a car, you're driving down a road and you're making all these subtle little adjustments to the steering wheel so much that you don't even know it. So to me, you know kind of threading that needle, you know it almost feels like that there's the risk of white people kind of colluding in white supremacy; there's the risk of white saviorism and those are real risks, I know that I can do both of those.

Some participants described other processes to “check” their efforts for racial justice work or not playing into white saviorism. Tessie describes how she uses her involvement with the community and the position she assumes in the racial justice work. Tessie says,

> Well, I don't know that I can make “sure” [that I am not playing into white supremacy or white saviorism] but the things that I do to try to be critically aware that is, the not being in charge, by practicing followership, by practicing accountability, by following the lead of people of color, joining them, and what they want to work on, not trying to get them to, you know join my parade. But I look and see what they're doing, and then I go see, by

> listening, and waiting, and trusting, those are watch words for me… I find ways, to participate.

Participants in this stage, like Tessie, Kyla, and Riley described the dual approach of questioning and interrogating their internal motives while participating in racial justice work. Kyla says,

> But I feel like that has to be in our minds, that has to be a part of it... Like this is not for me to continue to have power or feel good about myself … I'm in a place of knowing, that I'm part of the problem, and that I also have to try to continue to fix it. Continue to trust other people's experiences, and to help bring about change, so that I'm not a burden to them.

Riley says, "And so, it's always a question, first to me, and I still have trouble with that. I still have moments when I'm like yeah, I got this. And then, something totally blows me out of the water. And I'm like, nope, definitely didn't understand that, at the depth, that I really needed to." Participants also described their understanding that white people have a responsibility to be intentional in making personal and systemic changes to change racism and white supremacy. Yet, they also describe the danger in white people leading that work. They described the importance of constant self-interrogation. Kyla says,

> Well, of course, white people need to be the ones to solve it. But then I worry was that me just being a white savior, like I've come to rescue people…I mean it is that we've created this problem, so we need to be the ones to solve it. But by solving it, white people need to listen to other experiences and know that we need to help figure out how our systems are totally set up to fail people of color. And then make changes, whether you

> know incremental changes, or changing entire systems. Because we've created those systems intentionally.

Mary says,

> The words, cultural humility, is what comes to mind. When you're doing this work, it is that it's a learning experience, and I have no answers. And so, I think just trying to be aware of my positionality is all that I can do, and not being defensive, and being, you know, being open. Like, if I'm told this isn't working, I say…'Okay, how can I be better? What can I do?'

Riley says, "I mean it pushes me deep into myself. I think if you're going to do this work in a way that is intentional and thoughtful and compassionate you have to start with the self often, and you have to be willing to question everything about yourself." Jacob says, "I've really worked at, you know, recognizing and minimizing any kind of self-congratulation; and that I have to really do this because I believe it's the right thing for everybody. And I'm just one foot soldier among many. There's nothing special about me."

Participants in this phase discussed a sense of solidarity in purpose, collective action, and the interconnectedness of racial justice with the fight for other injustices. Loretta says,

> So [I feel] disempowered at times. But, in general, you know I think it's helped me continue to feel connected to a global society. I can say, like for one example I've always been somewhat like interested in climate change and climate justice. But, in particular the deeper I've gotten into anti-racist work, the more clear, it is that disproportionately communities of color and indigenous communities are being affected by climate change and that climate justice and anti-racist work are very, very well integrated.

Amelia says,

> [Racial justice work] It definitely feels like it's made me uncomfortable you know, in a way that I think is really important, and I'm happy to have been made uncomfortable. In some ways that's one of the biggest things that sticks out to me, but also coming to deeper understandings of what it really means to understand and support and be connected to people.

Tessie says,

> As a person trying to live into an anti-racist identity, I have a greater ability to feel and I have a greater ability to see. I have a greater ability to love. There is nobody I can't love. Nobody is off limits to me as a person, who I can see as human, and I can attempt to be in relationship with and the joy that comes from that.

Along with the freedom to see everyone as someone to be loved, other participants like Riley describe the responsibility that comes with being in a relationship with people of color and being involved in racial justice work. Riley says,

> So, finding, I think, trust, is such an important part of racial justice work. And trusting not only that racialized folks and the folks of color I work with, see me as trustworthy, but see me as someone that they can give feedback to and that I'm not going to flounce.

Participants in this stage described the intrapersonal work they engage in and the love and trust that develops when individuals are in "coalition" and "community" of racial justice workers. They described recognizing the "humanity" among community members and the impact it has on their lives. Amelia says,

> Like this idea that we all really do belong to each other, and to deny, and to not be real and to not seek to change a system that causes such harm to people that I personally care so much about, but also just collectively care about, has been a challenge, but a good one,

> too. I come back to this sort of connection between people and the need to make things better or right, or closer to right, it feels really compelling.

Riley says, "I gained love. I gain radical sort of experiences that sort of transcends just individualism into community movements and connection." Remi says,

> So being able to have that trusted network that came out of a racial justice space has made me like really good friends, but also like being able to continue my career. Because I don't know if I would have people, I trusted like that, without doing this type of work together.

Riley says,

> So, I gain perspective in the sense that I know a little bit better where to be and how to understand my place in this work and in the world. But also, just understand the world a lot better. I feel like I'm not just like walking around like a blind sheep who doesn't know what's going on, or the systems that are dictating the way I get to move, why I get more choice, why I get more agency. By being aware of these things and *not* being swayed by the systems that have been historically built on racism. So, all of those things, I think I gained [by being involved in racial justice work] and probably even more, I haven't yet figured out.

Jacob says,

> I feel like when you're doing something, when you're engaged in the struggle, it gives you a sense of meaning and identity in that process and also connection with other people doing [racial justice work]. I gain, a sense of meaning and purpose that I'm doing something that reflects my values and then I'm not being helpless. You know I think it is

so easy for white people to say, well, what can you do about it? [Racism and white supremacy] It's so big, it's so complex.

Allies and Accomplices. Amelia says,

> My hope is that, it's, the huge gain is that you are more connected, and you can truly support people that you are connected to in a way that you couldn't if you as a white person just continued to stay in your little kingdom of privilege and go off with your life. I just think there's a realness to being aware of racism and seeing how you can be a part of shifting that, so that other moms and kids don't have to go through horrible things because they shouldn't have to go through horrible things.

Participants in this phase, coalition and community building of anti-racism identity development, saw themselves as part of the community of people with a common goal of fighting racial injustice. They sought exposures that encouraged their growth and commitment to work alongside Black and other people of color. Loretta says,

> Maybe like allyship would be the other thing, like being kind of already willing or able, or seeking the experiences of exposure to other people, other cultures, or other communities being able to hold the discomfort of being around folks that are not fully like yourself and finding meaning in that.

Amelia and other participants also expressed that the journey to ally themselves with the racial justice work is important. Amelia says, “what it really looks like to strive to be an ally, not to call oneself an ally, but to strive to be that way.” Participants like Ailene found that the acknowledgement and feedback for the racial justice work that they are trying to do is helpful and has been important in their work. Ailene says,

> I really have appreciated in particular the acknowledgement from them that, that we all need to be working together, and that they need allies in the process. That's been made very clear to me. Because sometimes, I'm hesitant to take on leadership roles. Because I am not a Black person and so that's not my life experience. But I think that there's been a lot of really open conversation about whose responsibility it is, to do what, and that's been really helpful to me.

Performativity. Other participants, like Aiden, shared their desire for their racial justice work to reflect their inner conviction and core commitment to fighting racial injustice. They drew a distinction between "performative allyship" and being an "accomplice" in anti-racism efforts. Aiden says,

> I listened to a podcast several months ago now where some white women were talking with a black friend of theirs. She does work in this area, and I remember her saying that, having that discussion and making that distinction between like an ally, is just like someone who's kind of like you know sort of just there, whereas an accomplice is somebody that's like ready to like get in the car and go with you and just say, 'let's go.' And you know, whenever it takes you, 'let's go do this.' And I thought, I want to be an accomplice. Like I, it's not performative. And I know there's a lot of discussion around performative allyship but, but my endeavor is to be a good accomplice.

Emily says,

> It's just been increasing awareness of actually how the world works and I'm so grateful to see that, because then I can leverage, who I am, and what I bring, to try and do something for that [racial justice] and it's great to feel part of a movement, to chip away at some of these things.

Participants in the community and coalition building phase of anti-racism identity development see the work as bigger than themselves and envision the collective good that can emerge from racial justice work. They describe a "mission for racial justice" and envisioning a "healthy community that is evolving towards justice." Loretta says,

> I do believe that a healthy community and society is evolving, and growing, and responsive. and I'm starting to read and look a little bit more into like emergent strategy or emergent planning versus like strategic planning, because that leads into some of those beliefs around responsive change.

Participants describe embracing the "mission for racial justice work" and this propels them through the fatigue and challenges that arise doing racial justice work.

Rowan says,

> I believe in working in a place where I am supporting a mission that I believe in. And so far, whatever stresses or difficulties there are throughout the day, at least at the end of the day, I feel good about what I do. I feel like you know I'm working towards a better a better world, even in what I feel is a very small way, in a very small corner of the world.

Participants, like Liam, in this phase described their ultimate hope for the outcome of their involvement in racial justice work. Liam says,

> If we create a society and a workplace where there's justice and equality for all regardless of the color of our skin, then we create a society that is stronger and has more good people in the right positions, where you have better professionals, better teachers, better doctors, better engineers, and better scientists. Because limiting our pool to a "false" sense of the people who are qualified then just simply narrows the pool…. Ultimately, it may be a naive idealistic viewpoint, but I do think that if we create a societal structure

> that results in, yes, opportunities for all, to be educated, to be able to grow in the workplace, and to represent and be represented in leadership, you will create a self-fulfilling prophecy, where you know the next generation will be inspired by the previous generation and then you only snowball and it will benefit everybody.

Loretta and Tessie sum it up. Loretta says, “Then, humility, that I’m always willing to learn and evolve, because that's how we all move forward. Again, I don't like static. The goal should never be to be static, or arrive, or maintain the status quo.” Like Loretta, Tessie sees the work as ever evolving and ongoing attempts to dislodge the status quo. Tessie reiterates the links between the past and the current era of white supremacy, racism, and efforts for racial justice work. Tessie says, “we can't understand the present, unless we understand the past; and if we don't understand the present, and what needs to change in the present, we are creating a future without intention. So, there's a relationship between the past, the present, and the future.”

Participants embraced community with other white racial justice workers, Black and other people of color to create a broad coalition. They were intentional about learning from past racial justice workers and from the literature of Black and other people of color, whose voices described the struggle for racial justice. They described constantly learning and adjusting their approach, and challenges that were both intrapersonal and interpersonal as they evolved in their anti-racism journey.

Summary of Section Two

In Section Two: Anti-Racism (Racial Justice Worker) Identity Development consisted of three sub-themes 1) Recognizing and Bearing Witness: Reconciling Personal Convictions of “Non-racism;” 2) Intrapersonal Processes for Identifying and Embracing Racial Justice Work 3) Evolution and Phases of Anti-racism Identity Development. The sub-themes delved into

participants' perceptions of their experiences becoming anti-racist and the evolving journey to being racial justice workers. The discussion in section two includes the evolution and phases identified by participants that marked the maturation of their anti-racist efforts and their ability to see themselves as marked by white supremacy. The discussion highlighted the participants' emotional toll and the role that racism and white supremacy played in their pain and *always* ongoing process of unlearning racism. They also described their joy as being a part of the evolution of their anti-racism journey. Finally, they shared the love they experienced, the sense of meaning and purpose they gained, and their vision of the collective good of racial justice work for the community and the future that racial justice work could bring about for humanity. Participants problematized the dissonance of feeling joy about the hopefulness they experienced being involved in the "community" (Black and white people) of racial justice workers and the constancy of their implication in white supremacy.

Section Three

Theme Three: Reconciling Racism and white Supremacy in Healthcare

The third theme, “Reconciling Racism and white Supremacy in Healthcare,” described participants’ perceptions of the presence of racism and white supremacy in healthcare and the implications for racial justice work. The theme Reconciling Racism and white Supremacy in Healthcare encompassed three sub-themes: 1) Evidence of Racism and White Supremacy in Healthcare; 2) Motivation for Making Changes: Engaging Other White People in Racial Justice Work; 3) Future Initiatives for Racial Justice Work. In this theme, participants stressed the importance of framing the historical and contemporary context of health inequities. Participants noted that the foundation of healthcare is grounded in false assumptions and pseudo-science. Participants discussions indicate their life-world and recognition of the ongoing systemic racism and white supremacy within healthcare and elucidate the social and physical consequences of white supremacy and racism on the bodies of Black patients. They also discuss initiatives for change that include collective and structural efforts for anti-racism.

Sub-Theme One: Evidence of Racism and white Supremacy in Healthcare

The first sub-theme of the theme Reconciling Racism and white Supremacy in Healthcare is Evidence of Racism and white Supremacy in Healthcare. Participants in this sub-theme highlighted the need to clarify that health “inequities” for Black people and other people of color are causally related to white supremacy and racism in society, medical research, and healthcare provision. Participants described the systemic nature of racism and white supremacy in healthcare that began with the enslavement of Black people and the genocide of Indigenous people. Jacob says,

So, I think that this country has an original sin, and you know the sin of enslavement, and the sin of genocide, and land appropriation, and that led to inequities from the very beginning that have never been ironed out for a race, so I guess I feel like it's still baked into the DNA of this country.

Riley says,

And when we talk about even you know crime or gun violence or those sorts of things, you know it's always saying that these people are more at risk or these neighborhoods, and as soon as you start asking people why, then that's when they start getting uncomfortable because they're just so happy to just blame it on the skin tone or blame it on the biological reason.

Participants described racism and white supremacy impacting healthcare across all systems of health provision. Jacob says, “And when I said that about doctors and medical care professionals, I could say that about social workers, you know when it comes to social services, psychosocial services, mental health, the same type of racism and white supremacy is going on.” Caroline says, “I think that the implication in healthcare is that [racism] it's so baked into the system that it's not individual. It's so systemic how it's directed, how racism is just perpetuated.

Kevin says,

In general, you'd see that the outcomes are better for white people than black people in pretty much every disease you could write an article about. I’m sure any disease; I’ll bet you whether, it's about, you know, kidney stones or all others, and anything you can think of, and find statistics, and see that in general, the Black people do worse.

Riley says,

> And so, when I think about health care and the biological assumptions that have been made throughout history and how medicine has been developed, how we understand bodies, how we understand brains. Healthcare has been just constantly built on these false realities, these sort of assumptions or pseudo-scientific "findings," whether it's brain and skull sizes to create these weird like racial categories like caucazoid and mongoloid and those sorts of things, or the idea that Black women can sustain more pain, or that sort of thing. That's why we see these sorts of long-standing healthcare practices that create disparities and biases among them. But also the absolute disgraceful sort of treatment of particularly, Indigenous and Black people in the United States, by doctors doing experimentation, you know, like the Tuskegee trials and syphilis trials and those sorts of things. Or, even maternal health and reproductive health, and thinking about how women, particularly Black women, have been used historically to further those medical practices against consent, against sort of compensation, if that even.

Participants' explication of the historical foundation of racism in research and with the use of Black women's bodies implicates them and their research that draws from and rests upon that foundational knowledge. Their understanding of how racism and white supremacy continue to perpetuate throughout their specialty practice gives insight into the contradictions of their participation in healthcare and their quest for racial justice. Participants like Jacob, Loretta, and Emily see the racist harm *and* they situate themselves in the interactions that perpetuate the harm.

Jacob says,

> So, I think you know we talk about things like high rates of diabetes, hypertension, things like that... I think, too often [health inequities for racialized people] it's seen as like

individual lifestyle choices, and I don't see it that way. I see it as systemic, structural, collective processes that then affect people's lives, whether it's health or mental health.

Loretta says,

> So, it's I think the system things, or the big things, right. The things like who is writing the textbooks; who is leading resident training programs: who is coming up with that algorithm and reviewing it; and who's peer reviewing articles. I think those honestly have the most impact on the system, but so much of that is invisible. To the everyday person, I should say, you know folks walking around who don't work in healthcare, that piece is invisible to them, just like you know, probably any other specialized field would be to me.

Emily says,

> Because people are so afraid of that word [racism] and they shouldn't be, but we're not there yet. But I think with that interpersonal piece. People that are white health care providers, whether they are social workers or other, are not aware of how they bring their whiteness into the assessment room, into the treatment room. The lenses that they [white healthcare providers] use to view their clients. So, we [white healthcare provides] are not taught to have that reflectivity, and reflexivity around our own whiteness, and how we may be infusing that [whiteness] into our work.

Riley says,

> Because, then when you start asking those questions, people say well how else would we practice? And it's just, this again, that's a place where whiteness just robs us of our imagination. It robs us of thinking of what could be different, because this is just the way it is, and if it were different, then I, as a white person, don't have this privilege or I'm not

> "safe." And so, we maintain that status quo because that's the way it's always worked, and we feel safe as white people in that healthcare system.

Participants implicate one-to-one interactions, research, revenue, and scholarship as barriers that impede racial justice work within healthcare. They attribute the ambivalence to health inequities that disproportionately impact racialized people to the racism and white supremacy in healthcare. Participants express that fundamental to the lack of motivation for change is the dehumanization and devaluation of the lives of Black and other racialized people.

Amelie says, "this system of the big picture question that gets, I think, reflected in healthcare work, which is: who do we value; whose lives do we value; and what systems have we then set up to devalue or value less the lives of people of color, people without access to health insurance; and that becomes a big question." Riley says,

> And so, I would say, healthcare, as much as we want to laud the progress and value. So many of the different practices have been built on literally the skin cells of black people and we don't recognize that, and we have never given reparations for that, by any means. And so, it's sort of this weird like, not even a double-edged sword, it's just healthcare is wrought with it [racism and white supremacy].

Riley says,

> There's a famous quote from Bishop Oscar Romero, an El Salvadoran bishop, who led sort of a revolutionary movement there. But he always said, 'give a man bread and people will be so happy with you, but if you ask why he needs bread and why he is hungry, in the first place, people will get so angry.' Because you're pointing at something they don't want to recognize; and I think that's the issue a lot with health inequities, is that we tend

> to actually sometimes reinforce stereotypes of these populations by talking about health inequities outside of the context of their causes.

Loretta says, “So overall, I think the system has developed in a way that continues to privilege one group. [It] continues to maximize treatment outcomes and treatment options for one group and that is too narrow to support a healthy community.” Riley says,

> So, we name the problem, but we don't frame the cause of that problem. We're really good at saying there's so many inequities but we're not good at, then, following that up and saying this is the reason for those inequities when it comes to the social and systemic issues that are around these populations.

Riley says,

> It really drives people into a deeply biomedical model that sometimes people rely on way too much, which you know, in a sense, is exactly what racism is. It's this pseudo biomedical model that people rely on way too much to make decisions about life. We love a biomedical reason for things you know because we don't want to believe that social systems can impact health. Because health is all about microorganisms and muscles and those sorts of things. And because those are easier to fix than looking at ourselves deeply and saying, hey this social system, and these policies and these beliefs, that you carry with you are creating problems on a larger scale than one muscle group could fix. That's a harder lift, and people are afraid to make that lift because of the work that it would take.

Participants noted how the practice of healthcare, from research to healthcare provision, is primarily based on the needs, outcomes, and health of white people. Participants’ revelations implicate them as white people, and their knowledge and actions are within a life-world

contextualized by racism and white supremacy. They see the presence of white supremacy and racism in their education and leadership of healthcare and from patients directed to Black providers. Their revelations also convey a sense of hopelessness about racism and white supremacy. Ava says,

> The research that we do is always on white people, typically on white men. The research that we read, the research that is printed, you know, the signs and symptoms of a heart attack are like the classic examples. That's a study that's usually done on white men. And so, then, when Black people come in come complaining of slightly different symptoms or of pain, it's always dismissed, which causes misdiagnosis to be a massive problem. And then, also just making [healthcare] it a space where people feel comfortable. Doctors' offices are not a space where most people feel comfortable. But specifically, they're geared towards a white audience, and it's everywhere.

Loretta says, "If those individuals at the top and leadership are not receiving that education and are not actively committed to be anti-racist, not just have the sense or the desire to be equitable in their treatment of patients there's just too many cracks to fall through." Jacob says,

> I see people of color are constantly misdiagnosed by white medical care providers and that white standards of health are imposed on people of color. So, not only do people of color experience more stressors due to white supremacy and racism, but then they encounter a racist healthcare system. And, and I think that it's diabolical because it just exacerbates and reinforces the health consequences of racism.

Loretta says,

> But unfortunately, a lot of the policies, practices, and recommendations that we make were founded on research that excluded people of color and that work matters. We've

been talking about how algorithms, for example, algorithms about heart failure when there are still points assigned or part of that algorithm is racial identity or ethnicity, that can change your treatment recommendations and not always with a lot of good evidence behind it for the why… That's just one example, but, in particular, with cancer research, with infectious disease research, even with coronavirus, which I think a much better job was done with COVID, it was much more intentional.

Joyce says,

> I mean, it… [racism] can come from patients or physicians or loved ones and I remember my boss was saying that she saw a patient like in a primary care setting, an adult patient. And the patient walks up to the front, and she saw them with a preceptor, of course. She remembers, the patient walked up to the front and said, 'oh I don't need to pay for this visit right, because I saw a black medical doctor.' I'll just never forget those things.

Interpersonal relationships with healthcare providers. Participants under this sub-theme shared the systemic nature of racism and white supremacy in healthcare; they also described how racism and white supremacy are perpetrated through interpersonal interactions between healthcare providers and patients. They described how healthcare providers see some patients as underserving of treatment, and these are patients whom providers are less likely to believe about their symptoms. They also describe how racialized patients, rightfully, do not trust providers to give them the best care possible. Caroline says,

> So, yeah and then by the time you end up in the hospital, the nurses…you're labeled. You, being people of color, who have been gate kept from all of these other institutions to access all of these things that white people have access to readily, are then labelled as non-compliant, or obstinate, or unwilling to cooperate.

Chloe says,

> Most of our providers are still white and male and aren't probably given as much education about anti-racist theory in Medical School, I would guess. And so still they are more likely to, I think view a patient who doesn't agree with their treatment plan as "combative" or "non-adherent," if they're Black or Latinx. Whereas I think a lot of time with a white person, they're like well, 'they just didn't agree with this plan,' maybe next time.

Caroline and Chloe point to the heart of how racism and white supremacy interfere with racialized people's healthcare treatment. Kevin's statement gets at the lethality to racialized patients of racist thinking by white healthcare providers. The assumptions about the racialized patients that Kevin and Ailene express are based in white supremacist logics. Kevin says,

> So, if you're coming in, and none of the people look like you. Then you figure you're not going to get the optimal care. You're not going to get optimal understanding of what's going on… I think a lot of people [doctors] just give up, and say 'well, this is a really tough case, and you know she's going to do badly', and [the patient] they end up going into [organ] failure.

Ailene says, "And so, the medical providers' misconception of intelligence of patients of color impacts, those explanations of what's going on or asking for informed consent, or you know all of those things."

Remi says,

> We know that men, Black men who experience pain, are the least likely to be believed by providers and most likely to be labeled as drug seeking. We know that people with sickle cell disease, who are not all black, although the most are, who experience probably the

> highest level of pain of almost any emergency person coming into those spaces, outside of like you know, an accident or some sort of like work incident. And even though there's proof of sickle cell right, it's not even a conceptual issue, they're denied medications.

Participants describe how white supremacy and racism intercede between the racialized patient and the white healthcare provider—leading to racial tropes regarding levels of intelligence, non-compliance, or uncooperativeness. They describe how the intersectional identities of race and gender work against Black men when they report pain symptoms. Participants describe the racist decision-making that can impact the racialized patients' care and produce dire outcomes for the racialized patient.

Ailene says,

> I think like communication is a huge problem. So, most health care providers are white, but they are working with people of color, people from different ethnicities. Or, even you know, I know we're talking about racism, but you know just refugee populations even then white healthcare providers don't always know, what they don't know, and sometimes they're smart enough to ask, and other times they make a lot of assumptions, or intentionally, just don't care and that really contributes significantly to those inequities.

Ava says,

> …That's an internal implicit bias that you have, for whatever reason, right. Maybe, somebody told you that and you didn't question it, or whatever. You're [healthcare provider] not going to hear the actual problem. Because A) you didn't connect with the client; and then, B) you're refusing to see what they have to say is valid...If you have access to doctors that aren't going to listen to you, and don't connect with you, and don't

form that bond with you, it's not really access to health care. That's just access to another person that's gonna make you feel bad.

Riley says,

> Because, then when you start asking those questions, people say well how else would we practice? And it's just this again that's a place where whiteness just robs us of our imagination. It robs us of thinking of what could be different, because this is just the way it is, and if it were different then I, as a white person, don't have this privilege or I'm not 'safe.' And so we maintain that status quo because that's the way it's always worked, and we feel safe as white people in that healthcare system.

Charlotte says,

> So, we see it, when [specialty doctors], at least in my world you know treat different patients differently. And thinking about compliance, I often hear particularly white practitioners having more trouble with 'compliance' with Black patients or Latina patients who don't understand the language that they're speaking because they refuse to get a good interpreter, you know and those sorts of things. So, it's this language [compliance] that is pervasive where you know, because they're [Black or Brown patients] not meeting *me* where I'm at as a white practitioner. Then, it's clearly their fault, and it's not the fault of the system in which I'm working or the biases that I have. So, [racism and white supremacy in healthcare] it creates lack of access, it creates lack of quality evidence, and quality care, less client centered care.

Remi says,

> With the opioid thing, it is like who's getting access to the care? It's still certainly not the communities of color that were impacted and we're not releasing and commuting

> sentences of people of color that were caught up in all these DARE busts and drugs stings of the 80s and 90s. But no, now we're talking about it as like 'oh no, opioid addiction is so *hard*, and all of these things.' But when we talk about it with people of color it's not l ike that. But as soon as it was white and perfectly, white middle class and upper-class people that were navigating addiction, suddenly there was an opioid crisis.

Participants noted how, due to racism and white supremacy, medical and social issues rise to a level of importance when they begin to impact white communities. Health inequities that are primarily experienced within racialized communities are likely treated as individual deficits. Participants noted how this way of thinking and *doing* healthcare also had negative impacts on white people.

Loretta says,

> So, everybody's disadvantaged that's kind of how I see it. Even when you walk into a doctor's office, I think we all, we all, being, anyone who's not a white man, generally, know that the way in which we present our concerns may be perceived differently by doctors. I think most of us have had the experience of not feeling safe or believed in a doctor's office, and that is not an experience that is typically shared by white men who present for medical care.

Remi says, "I mean it looks like a lack of distrust, a righteous lack of distrust of providers means people are less likely to go into care, especially for preventative treatment. So, then they wait until things get much worse, so we have higher rates of mortality and those things."

Chloe says,

> I just think we need to restructure those conversations and how we walk into a room. And acknowledge how much power we hold if we are wearing a white coat, and bringing in

> our laptop and applications, in the eyes of the [racialized] patients. It needs to be more of a collaborative conversation about how someone wants to improve their health, rather than a bunch of check boxes.

Amelia says,

> That I am believed and attended to, in a different way than a Black woman my same age who goes in and talks about being in pain. So I think that there's the bias, I guess within providers themselves and within the system, that means that people of color may receive worse care, like a lower level of care, than I might as a white person seeking health care services. The bias that happens within systems, the way that healthcare providers who are people and who have swam in the same water are treating people differently, based on their race and ethnicity.

Emily says, "Just the fact that so often our interactions, especially, go unexamined. I mean, in social work, we would talk about whether you know supervision does that, which I don't think it does, a lot of times. I don't think we're taught how to supervise people around their racism."

Joyce says,

> There was a doctor that had referred to a Black patient as like, just like, not a nice name and like not in front of the patient, but in front of the medical school students. The med students were very like disturbed because they heard that. I hear about a lot of that stuff because of my role in teaching, and the scary thing is, it's not from just from patients, it's from like attendings, it's from residents. I mean there, there is that kind of behavior in all of the areas of medicine.

Ailene says, “Yeah, I think that there are a lot of ways in which white healthcare providers, maybe, are not as well informed, or are informed, but disrespect the ways in which Black individuals experience health and wellness.”

Emily says,

> If we expand healthcare to think about child protection, you know, broad based stuff. We know that racism is infused into how we look at investigating potential child maltreatment. We know, of course, about the disproportionality and disparities separately, that are evidenced in the child protection system in terms of tracking kids by outcomes, same with juvenile justice, same with criminal justice, you know, addiction to the same extent. So we see, I mean it [racism and white supremacy impacting healthcare] really comes down to personal racism in interactions and structural racism in terms of over representation or under representation, depending on the issue.

Emily says,

> So, I mean, I think there's faulty assumptions that health care providers have about Black communities, that are based on faulty data. If you think about maternal mortality, we know that the care for women in the process of having a baby is problematic for a number of different reasons, again, both structural and interpersonal and that leads to poor outcomes for babies and Moms.

Kevin says,

> If you've come here and you don't find a Black doctor, you might not think that the white doctors are listening to you. In fact, that may be correct. I have witnessed, there are sometimes people write them [racialized patients] off. ‘You know they're not going to complain;’ ‘They're not going to give you any trouble;’ ‘You just tell them stuff, and then

they go home.' But it really depends on how aggressive you want to be with your patients, and how much you think they're going to complain about you, and if you think you can just write them off and you can get away with it.

Cultural competence, cultural humility, and competent care. Participants noted the differences they saw in cultural competence, cultural humility, and competent care.

Ava says,

> Yes, incompetence, because a health care professional's role, is to first and foremost connect with the client, with the patient. Then once that connection is made, once that relationship is established, then your [healthcare provider] job is to make them well. [It] is to find out what they need, and to make them well, that's the job. If you're [healthcare provider] entrenched in racism which you are going to be, and if you're unable to see that in yourself, and unable to mitigate that, then you're not going to be able to connect with the client which is the first step and you're [healthcare provider] not going to be able to hear what they have to say.

Participants under the sub-theme reconciling racism in healthcare also shared their interrogation of cultural competence and their push for competent care. They noted the tension they felt with the idea of cultural "competence" and yet the need for competent care for Black and Brown people. Participants shared that the two were often not the same. Participants noted that racism and inequitable treatment called for educating themselves and other healthcare providers. They cautioned against the "essentialism" that could accompany cultural "competence" trainings and approaches and shared their perceptions of the harm this causes. They also pushed against treating people with a "Westernized one size fits all" approach that does not acknowledge the impact of racism and white supremacy in healthcare for Black and Brown people.

Chloe says,

> So, I think [racism and white supremacy] it impacts in every single way. Even, especially, I notice interactions within the health care system where there's this element of power of what it means to be healthy and none of it really comes from a cultural lens or altering the community environment to make it healthier. It's all very individual, like individualistic, which is a very white concept. So, I feel it impacts in all these ways all these tiny ways that amount to very big things.

Ava says, “The systemic and pervasive racism, causes health inequities, and then exacerbates the health inequities because of access to competent health care. And, competency, I think, is just as important as the access to the health care.” Charlotte says, “Then, I think that one of the things I struggle with, too, is knowing that the beliefs and opinions of different cultural groups, different racial groups, different ethnicities are quite heterogeneous and so, I worry about making assumptions right, because I can learn from all of these sources.” Aiden says,

> I think that there have been some efforts over the years of trying to look at cultural competence and some of these other sorts of phrases, there's a risk for essentialism or tokenism in the sense of saying that you know all Black people are like this, or this is how we should interact with all Native American people like this.

Charlotte says,

> And I can try to integrate that into the way I’m thinking about the world and thinking about my clients. But the same way that I don't have the same beliefs, as every other white person I can't assume that my client is going to have the same beliefs as my [Black] colleague who I’m consulting with about something, and so I get really stuck there on that piece of worry, maybe I should just let it go.

Aiden says,

> I think part of what needs to happen is there's a recognition for as much diversity within groups as between groups and how to help health care providers and educators, to think about how those things come into play, in terms of the ways that we design, the way we deliver education, and the way that we design our health care delivery as well.

Participants under this sub-theme noted that for them reconciling racism in healthcare also meant coming to terms with racism and white supremacy with a culturally humble approach to trying to bring change. They noted how the conversations about appreciating difference and diversity and anti-racism in healthcare had to be integrated into the way new healthcare providers are educated and woven throughout their personal and professional lives. Amelia says,

> So, having [the impact of racism/white supremacy] that be a pretty regular part of our discussions, but also talking about cultural humility and I don't want to raise kids that think they have it all figured out or that they alone are going to stop racism, but really having those conversations with, especially within my own personal sphere about the importance of awareness and learning and also not thinking that you somehow know it all.

Sub-theme Two: Motivation for Making Changes: Engaging Other white People in Racial Justice Work

The second sub-theme under the final theme, Reconciling Racism in Healthcare, is "Motivation for Making Changes: Engaging Other white People in Racial Justice Work." Under this sub-theme, several participants shared that engaging other white people in racial justice work was important for changing healthcare provision. Participants shared the dissonance inherent in trying to get other white healthcare providers to see themselves implicated in white supremacy and

racism in healthcare. Participants noted that it is an ongoing reconciliation between their participation in white supremacy and trying to get others to see the devastation wrought by racism and white supremacy. Riley says,

> So, you know, I think that for me, is just something to emphasize, I feel like I've said it but just that we [white racial justice workers] have to be very cognizant and very questioning always and use a lot of energy to make sure that we're showing up correctly, as much as we can, and to be the pads, not the show. And to sort of move that forward, rather than our own egos, and identities, and sort of almost resolution, or like licking our own wounds as white people. Like that's not the work that we need to be doing, you know it's about the hard uncomfortable work that that needs to be done.

Jacob says, "I do workshops on 'why it is so difficult for white people to see and understand racism' usually with mostly white audiences in counseling centers, schools, medical schools, and you know, various places." Riley says,

> But then I would say, like on a broad spectrum in [names medical specialty], most of the people that I'm talking to are white middle-class women. And so largely when I'm asked to go speak at a DEI panel or whatever, I am consistently trying to get white people to get engaged and take action and provide them, at least with the tools and strategies that I think for me and for the relationships that I've built have been helpful to start enacting those.

Remi says,

> A lot of my work is even just starting people on conversations, because my whiteness allows me to have those conversations in ways that other people won't. But then, also making sure, and this is something I've had to work on, is that I'm always centering

voices of color, and never like oh, what I think they meant was this. But to be like yeah, 'that was not, okay, and you need to l back down from that' or 'that was a totally inappropriate question.' And I'm going to redirect to this again over here, rather than trying to make you feel more comfortable for saying something that was, you know, middle of the road in your mind, but was harmful.

Rowan says,

> Yeah, I would very much like to be more involved with advocacy and kind of higher-level things. On a small scale, we have worked to roll out better screening for opioid use disorder in our clinics regionally here. So, I've been involved with a lot of the other providers who are white, and you know, reminding them of the huge racial disparity in treatment for the opioid use disorder trying to improve screening for non-white patients.

Participants noted that there are concrete advocacy activities that they are involved in, but they also work to make sure that the provision of healthcare within their sphere of influence integrates anti-racism. They seek opportunities to enact changes that will help individual patients and racialized groups. Participants' racial justice efforts impact micro, mezzo, and macro areas of practice. Participants point out the people they look to who model anti-racism practices. For instance, Riley describes how he models positive anti-racism interactions with racialized communities for other white healthcare providers.

Having Difficult Conversations about Racism. Riley says,

> So for me it's modeling and trying to show [other white] people at least ways that I have found to get positive feedback from the community of color and challenging them to be uncomfortable and do that work. So, in that way, in like personal relationships and

professional collegial relationships, I’m always trying to have those more difficult conversations.

Caroline says,

> There are a few people around you know. I’ve had a couple of white professors in the school of nursing who have just done a really fantastic job of just of centering racism and white supremacy as [problematic] and providing evidence-based papers that students demand for what the research says, what the detrimental effects [of racism and white supremacy] to health are. And I’ve also seen good modeling of white professors challenging [racist] things that students say, which I really appreciate. Because I hope to t each one day, and I find that challenging, how to address just the baked-in assumptions that people make and things that people say. It's often just the Professor saying things like ‘What do you mean by that’ or ‘why do you say it like that’, or ‘what do you think could contribute to that’ or you know these sorts of like ‘deeper dig’ questions, but just like the interrupters [that dig deeper into the meaning]. I appreciate their leadership and mentorship.

Chloe says,

> Whenever I’m interacting with employees, especially one on one and they're talking about a situation, I try to always come from the side of the patient and then try to educate about the situation and how to best serve patients that they are having difficulties with, and so I try just those little ways to educate and bring people in.”

Ava says,

> Yes, I have [tried to get other white people involved in racial justice work]

> and I think it's been somewhat successful. I think sometimes white people don't understand where to start, and so by showing them good places to start or just bringing them along with me or saying these are the things that I've been doing, that typically works.

Ava acknowledged the difficulty that she has—Ava says,

> I think it can be scary; and I have a hard time explaining to people why they should do racial justice work, other than it seems like the right thing to do. And so, then it becomes scary or uncomfortable for white people. That's the main hiccup I run into in my thought processes. Important things are uncomfortable, but that's maybe, not everybody's thought process. And so then, when I run into that hurdle, I have a really hard time understanding where people are coming from, and then explaining where I'm coming from.

Meeting White Resistance and Fragility. Participants note that conversations with other white people about racial justice is not always easy or comfortable. Participants often meet resistance when they discuss how they and their colleagues are perpetrating white supremacy and racism. This is particularly difficult when there are power differentials or pushback from peers aligned with power. Participants discussed getting others in power to see the advantages of anti-racism work. Aiden says,

> In other ways, it is curiosity, I guess, of how to get more people that are in positions of power to come along and think about what they can do individually and collectively to make changes, to give it attention, I guess. But also, I think about the challenges of working with other white folks around these topics and how to be able to talk, how to be able to let people know when things that they're doing maybe hurtful or not.

Liza says,

> In my clinical unit, with a lot of the work is also kind of a racial reckoning. You know, because [clinical work] is even more white as a field. And so, with them I am trying to sort of leverage that trust that they have in me, that's been built up over the years, to be a force of good and a force of change. I feel like they're kind of in a place right now, where it's like the kindest and most well-meaning people in the world, you know who want to liberate other people and I mean all of that, but there's kind of almost a like a hurt and a defensiveness that can come up. So, I feel like part of my role there is kind of gently trying to push us a little bit like past that hurt into really doing the work.

While other participants make a choice to engage white people who are open to learning about ways to enact change with anti-racism actions. Participants discussed how they invested their anti-racism energy in terms of their work with other white people. Participants agreed that they feel compelled to do the work of getting other white people involved in racial justice work and yet they also realize that the enormity of the work requires them to be strategic in their efforts.

Tessie says,

> It's interesting. I had someone say to me one time …We had had a conversation about how I, you know, came to be a person who cared about racism. And she said you know I don't want you to beat your head against the wall of people who don't want to hear about it. Don't waste your time trying to persuade people to care about racism. Put your energy among people who already care and don't know what to do and help them know what the next thing is to do. And so that's what I did … once somebody has hit that point of cognitive dissonance. 'Wait a minute. This is not how I thought the world was, I'm not who I thought I was. Now, what do I do?' So, I don't try to convince people to care about

> racism. Because if they don't already care about racism, I don't think there's anything I can say or do that can change their mind. You know, they have to come to that initial awakening, and then usually they are fearfully curious about what might be next. And somewhere in that conversation is usually where I offer the joy, promise. and that is usually intriguing enough to bring them into the next part of the conversation.

Kyla says, “I think the people who come to it, and you just know. You see them, and you know they're really there for it [racial justice work], and then there are other people who just don't and that's extremely frustrating, and disheartening. I know there's a power thing.”

Tessie says,

> You know I tell my fellow white people when I'm doing some kind of educational process or we're in some relationship that is intended to lead to learning. I'll say, I promise you this, if you will enter into this journey, and stay with it, I promise you there will be joy. And it blows their minds because you know all they can see is the guilt and the shame. And you know, what they're going to have to give up, and you know what's going to be so hard. And I'm like that's not the whole picture, you know, there's more to it than that. So, we lose a lot from being white, and we don't even know.

Mary says,

> It's more just like having conversations. Because I think, I mean, I think racial justice work starts with yourself. And as a white person, like you have to acknowledge there's racism, you have to acknowledge your white privilege. You have to get over your white fragility, and whatever anger and resentment you have. And I mean you have to think, embrace that you're the problem, and [you] can also be part of the solution.

Participants were cognizant of the connective tissue between the systemic white supremacy and racism in healthcare and the individual racist interactions between providers and Black patients or Black healthcare providers. Participants named incidents of white supremacy enacted through funding policies, research, education, and publication standards—all privileging one group. Participants stressed the importance of getting other white people involved in racial justice work as integral to their anti-racism efforts. Participants centered strategies such as modeling anti-racism efforts to getting those in power involved in racial justice work in order to make changes in health inequities for racialized people.

Sub-Theme Three: Future Initiatives for Racial Justice Work

Under the theme Reconciling Racism and white Supremacy in Healthcare, the third sub-theme is Future Initiatives for Racial Justice Work. Participants under this theme criticized the individualistic nature of the healthcare system's efforts to counteract racism and white supremacy. Participants called for collective and systemic changes from policy and funding analyses. Participants problematized the underrepresentation of Black and other people of color in healthcare needed to be addressed systemically. Participants shared that future initiatives for collective change must also address the determinants that impact the health of Black and Brown people.

Underrepresentation of Black people and Other People of Color. Participants under the sub-theme Future Initiatives for Racial Justice Work shared that underrepresentation of Black people as healthcare providers was directly related to racism and white supremacy in healthcare. Participants stressed the importance of increasing the representation of Black healthcare providers. They suggested that future initiatives for racial justice work must strive to overcome this challenge. Joyce and Charlotte point out research that points to better patient outcomes for

Black patients when they share that identity with their providers. Participants also shared that they questioned the ethics of knowing that Black patients may achieve poorer outcomes when treated by a white healthcare provider. Joyce says,

> For example, like a white provider to a Black patient or family, I think representation is really important. One on one, like, for example, we've learned through research recently that Black babies have better outcomes when they have Black physicians. And so, I don't even know that I understand, like all of the details of that research and, like all of the reasons why, but I think that speaks to like the one-on-one interpersonal aspects [of the impact of racism in healthcare].

Charlotte says,

> I mean there's some literature, that, you know, there are better outcomes when there's kind of a racial match between therapist and client. And so then, like ethically, am I, should I, be the one serving this person or, should I be doing something to get them, you know that match that's going to be a better chance of them having their best outcomes.
>
> So, I think of all those things kind of, at least for me personally. I think about all that.

Along with Joyce and Charlotte's points, several participants pointed out negative interpersonal interactions between white healthcare providers and Black patients based on the bias of the provider. Along with the interpersonal bias that exists, other participants, like Caroline explore the systemic inequities that keep underrepresentation of Black healthcare providers as the status quo.

Chloe says,

> In a work setting, I feel there's more empathy and understanding and better communication with the patients [by] Black employees. Most of our patients, or at least

half of them, but I think most of our patients are Black. So having that face when you check into your appointment, it feels a lot more friendly and inviting. When I talk about social stressors and environmental stressors, they are a lot more understanding when a patient may be upset than a white provider who's just like, 'I've had it with this patient being upset all the time.'

Caroline says,

> I think like an imperative is to have the leadership of healthcare institutions reflect the population who you're caring for, both on the board, but also, like in upper leadership, who gets hired, who gets promoted. Although Black women shouldn't only be nursing assistants but should also be at the CNO [chief nursing officer] level. And what policies are necessary to put that in place, you know childcare, PTO (paid time off), affordable housing. I mean it's all interconnected, yeah paying for people to go back to school, which [names employer] does offer, which is good."

Participants agreed that future initiatives to address racial injustice must include recruitment of underrepresented groups into the healthcare profession. Participants expressed that a focus on recruitment could range from efforts to increase financial assistance to providing holistic admissions that consider all factors in an applicant's admission. Aiden says,

> Those are some efforts, at least, in terms of increasing the pipeline we've been very intentional about trying to increase the diversity of doctorly prepared nurses. For example, recruiting students, first generation students of color into nursing programs, and I think that needs to be happening across the board in terms of the health care providers.

Ailene says,

> You know there's all this, there's so much, literature about holistic admissions now, especially for healthcare kinds of professions. And I think that the way people are interpreting holistic admissions, it's kind of interesting. Because there's a pushback, you know, should you be including ratings in that process and you know, pulling out, and giving special attention to people of color who are applying to these programs, or should you not ignore, or should you ignore it? And you know, just look at people's sort of qualifications otherwise. And there's so much discussion and debate about this and I think that there's a more complex answer than that, and that it comes from recognizing people's race *and* their other qualifications and looking at the entire package.

Remi says, “I do think that there should be more initiatives supporting Medical School scholarships, Medical School faculty of color, scholarships for folks of color.”

Rowan says,

> Specifically, in healthcare [initiatives to address racial injustice] first of all far and away, we have to recruit more non-white physicians into medicine. It is just, it is appalling that there are so few non-white students in the pipeline, and you know a lot of medical schools have just begun the kind of early steps of remedying that. But we know even empirically, we know that non-white physicians often will practice in the communities they came from. They [non-white physicians] also are role models to patients who are maybe young children, for example, who grow up seeing, you know, oh, I have a pediatrician who is a native American or who's Black and I am native American or Black and I could be this when I grow up. So, it's really important to get that cycle started.

Participants like Ailene see the need for providers that can understand the context of patient’s experiences. Ailene says,

> You know there are just all kinds of things that racism has contributed to that we are then, sort of ignoring in the moment. Because I, you know, see you as a Black woman. And you know, it's sort of like, well, I'm measuring you for who you are right now, without taking into account like how you've come to be who you are. And I think that's an important part of just increasing the diversity in our healthcare fields from the practitioner side. Because I think that is going to make a huge difference in addressing the inequities in the provision of healthcare services.

Other participants discussed the urgency of making changes that address the environment for current Black and Brown healthcare providers.

Loretta says,

> Recruitment is great, but it is very delayed. I recall a meeting where somebody very high up in leadership, one of the Deans said, "well, we're recruiting and in 10 years we will be there. I had to point out, …that our culture, right now, is not good, our culture, right now, is hostile and inhospitable, and often unsafe for our current employees of color, so it is not enough to talk about changing in the *future*.

Participants agreed that efforts to individualize interventions with bias and awareness training are not sufficient to make changes in racism and white supremacy, and future initiatives must go further and analyze policies and make policy changes. Participants also shared that anti-racism education needs to be a part of healthcare providers' required learning. Participants shared that in order to get to "racial justice," they were pushing their organization to move the needle past "diversity," "equity," and "inclusion."

Riley says,

> I think that white healthcare providers all must, when it comes to racism and trying to move towards some sort of justice in anti-racism work, is to start there, is to start with the assumption that you're probably not right. And you probably are functioning off of assumptions and biases, yes, but also the systems around you are forcing you into those decisions and that those systems are probably not right.

Remi says, “I don't think that a lot of what the [healthcare organization] is doing is racial justice, I think it is like entry level racial equity work, maybe I would give it equity or inclusion work, but I don't know if it's justice work.”

Riley says,

> I would say, on the flip side of that taking all of the energy that we put into implicit bias trainings in healthcare and orienting it towards policy change, and policy analysis, and looking at our hospitals and our clinics. Looking at our policies and the funding and where the money is going and how we're sort of contributing, not just to providing equal care, but providing reparative care and providing reparations to these communities that have been so historically minoritized and oppressed via the healthcare system. So, I am tired of sitting in rooms, with people telling me, you need to think about different hairstyles, like I get that, but, I don't think that that's going to change health disparities.

Kevin says, “Well, there are a lot of initiatives that have been tried, and I heard about a person who wrote a book saying how most of these initiatives have failed. You know you get this online training course on sensitivity, or you know, racial bias, and you have to push buttons and listen, and then you forget about it.” Riley says,

> I think that it's important, and it's definitely a step, and practitioners should definitely know about these things. But the amount of energy and time that's being put into it, as if

it is, a solution to broad health disparities is absolutely unconscionable to me. So that's my biggest thing is the initiatives need to look at policies, they need to look at funding, and they need to actually step beyond equality and step into anti-racism, which is actively trying to repair the oppression and challenge that we have had historically within the healthcare system, particularly in this country.

Remi says,

> There should be more classes in medical and healthcare spaces on the differences across race, not from a like a checkbox idea, but, like that acknowledges the harmful history of the medical, industrial complex and how even the research we've done has kept us from having information we need to treat people properly.

Owen says,

> I'll just say, right now, in the academy/university, I think that all instructors, professors, we can start right in the school of social work. Everyone should be required to take an anti-racism course whether you've been teaching this for 20 years, or you never have taught [anti-racism] it before, or you're a big-time big wig researcher, or not.

Joyce says,

> I understand that there are certainly people in medicine, who don't go through like a professional graduate program [so they have exposure to required learning about racial inequities in medicine and health care], but this can't be. Like I’m five years out of residency, and I suddenly like to come upon this work and I’m the one person who like did some of this work, because I have an interest. This should be part of the curriculum, no matter where you come up in medicine and health care. This required learning about racial inequities in medicine and health care and such.

Participants also noted how the curriculum, research, scholarship, and publishing are directly related to the lack of representation of Black and Brown people and racial inequities in healthcare. Participants expressed a need for change beyond statements of anti-racism by professional associations. Participants expressed that at every level of engagement, the pushback of white supremacy determines which bodies will be admitted into the whiteness in research, funding, and publications. Participants shared that change in this area is integral for future initiatives for racial justice. Liam says, “Well, I think that the governing bodies for research, I think needs to change and needs to incorporate efforts to greater represent racial subgroups in research conclusions.” Emily says,

> I just want to highlight that I think some of our national organizations are talking about it [racial justice work] in some of their publications and some of their rhetoric. But, I don't think it's trickling down enough into how people live their provider lives, their social work lives, their doctor lives, whatever it is, and that's a problem. We need to get better about making this real and tangible and possible for people. Because I think we figured out to some extent, to a great extent, how the structural pieces work with large federal or state policies. We can use our lenses to analyze those to identify areas of disparity, disproportionality, [and] oppression.

Participants discussed the pushback against substantive anti-racism systemic and institutional change they experienced within their respective healthcare settings. Participants expressed that along with each effort for racial equity, future initiatives must include a willingness of white healthcare providers to experience the discomfort of change. Participants discussed the resistance to experiencing “discomfort” as a significant stumbling block for white people and racial justice. Loretta says,

> So, in healthcare, specifically, I think one of the two big things is a lot of focus on recruitment. And I would say that with these initiatives, people in leadership, particularly white people, particularly white male doctors in leadership, need to be willing to be disliked. [They] need to be willing to be challenged, and need to be brave enough to say, even if this is uncomfortable for individuals to make these changes, or for our system to make these changes, we are doing it because it's the right thing to do, because this is equity work.

Liam says,

> As with most, big societal issues, I think that the most comfortable, are the most apathetic, and that includes white physicians. I think that there needs to be [change in this area]. Apathy I think is the most toxic thing in the privileged, you know this kind of [attitude]. 'Well, I'm fine, so why should I bother?' I think people need to be connected to and exposed to the reality of the imbalance. And if, that didn't happen, based upon what's been going on in the last few years, I don't know what will change their viewpoints. But it certainly has changed the viewpoints of many of my colleagues. But there's still some apathetic amongst them.

Participants expressed that part of their racial justice efforts with white people is pushing against the desire to maintain "white" comfort and avoid white fragility and the "non-racism" postures that white healthcare providers often lean into. Participants noted that several anti-racism initiatives would improve overall healthcare practice and outcomes, and yet, suggestions to make those changes face significant pushback from white people in positions of power. Participants discussed the dissonance between providing more "training" while maintaining policies and practices that harm Black and racialized healthcare providers and patients.

Loretta says,

> There's so many of these initiatives that are not inherently harmful to the practice of medicine and yet there's so much pushback [among healthcare providers] against those policies, practices, and initiatives. But we need commitment and bravery from the people at the top and leadership to carry out these initiatives, we don't need “training.” At a training [someone] said a wonderful thing. He said, ‘as a black man, I don't need a DEI program, I need a safe place to work that's it, for me, that's it.’

Liza says,

> I would love to see spaces in [my organization] and also in my clinical work where white people can know we're not there to justify or prove that we are not racist or anti-racist, but we come in with the assumption that we have been racist. I want to see a sense of urgency that we're not going to tiptoe around that anymore, and you know whether that takes the form of sort of caucusing, and you know I would love to see some it. I know that you know these spaces exist, and they probably exist better in a in a mutual aid way you know.

Loretta says,

> Speaking from my experiences with our [names hospital] department and push back we've gotten against [equity efforts], I don't want to hear that we have to be careful, that is not what I want to hear. [Having to be “careful”] that is in fact, again white supremacy, you're just passing on the discriminatory practice.

Liza says,

> I would still love to see some kind of institutionally supported spaces, where as white people we commit to doing this work and commit to really doing the work rather than

> trying to prove how much we've already done, which is something that we do in academia, a lot.

Participants expressed and that everyone must find a strategy to do their part within their context for anti-racism. Participants shared that these efforts often include building relationships within healthcare with other white racial justice advocates and with Black and other people of color to make change. Ava says,

> I don't remember who said this I use this quote all the time, and I don't remember who said it, but it's all about pushing on. Everybody push on their lever at the same time to make a big change. And so that's sort of what I mean by staying in your own lane, is I don't mean, like ignore everybody else. What I mean is, push on your own lever. My lever happens to be the health care space. So, pushing on every lever that I can find in my area to move the boulder that is oppression and white supremacy.

Caroline says,

> And I think that my hope is for relationship building within like the racial justice movement of like white folks, who are doing their work and people of color who are doing a whole lot of work that there are also relationships built in those pieces and then systematically in healthcare systems. That we are centering and remembering the importance of human relationships, as the foundation for why we want to do this work in the first place.

Caroline says,

> Just one final thought, I have is, like, I do think it's really important for white people and white healthcare workers in particular to self-examine, and you know kind of caucus and do our work together. But I also don't want that to be in a silo. You know I just really feel

> though, like genuine relationship building is so important too. And I do think healthcare facilitates the very natural [relationship building] especially nursing. I mean those people that you work on the team shift with, like you are in it together. Like, it doesn't matter what their political beliefs are. Like if there's a code, you're going to run it well together. You're going to try and save that person's life, like somebody's going to be the timekeeper, somebody is going to be doing compressions, somebody is going to be pulling, you know, like you're going to function well as a team. I do think there's a lot of value in that, that we can take to other parts of society. We have to figure this out together; we have to work together.

Tessie says,

> So, I think taking the lead from people of color, putting our energy into what the people who are (like I'm not trying to say that it's the job of every Black person, to be about racism for instance) but for those who have chosen to make it their work and who are open to being in partnership with white people, okay, that's where you go. That's where you follow the lead of the person who has a critical awareness, who's committed their energy to this work. Okay, see how you can join in, do so with followership, do so with humility, with accountability. don't take it over, you know, and if somebody calls you out, and says this is the thing, calls you in says here's what you need to pay attention to. Okay, do that, follow the lead of what's being offered to you. So, it's you know it's a little complicated to find your way between you know, those poles, but it's possible, it's doable.

Structural/Social determinants and Anti-racism Actions. As mentioned, participants noted that efforts to disrupt racism and white supremacy in healthcare must include the

interpersonal relationships. They also shared that racial justice work and actions to further anti-racism must also tackle the social determinants of health to include insufficient housing, poor educational and economic opportunities.

Amelia says,

> One element of racial justice work that seems important is that the individual relational pieces is what I think we have this immediate ability to think through, but [we must] also [think through] the bigger structural pieces of what kind of a system have we set up, and how do we correct that, so that we're not just perpetuating more of this, because we're stuck in systems that don't allow us to shift things in a bigger way.

Joyce says,

> I can't understand necessarily what it feels like to go through life as a person of color and so and I certainly don't like pretend to, or claim to, in my interactions with families. I do try to understand like from a social determinants of health [perspective], like our clinic is like really good at understanding like social determinants of health and like reflecting on these things as a group. So that as providers, we can understand our biases and try to know what those are so that we can take better care of patients.

Riley says,

> What my whole career has been built on, as an [community provider] in the United States has been to think about ways that we can be out in the community, more effectively and not contributing to a problematic healthcare system so that's probably like 40% of my time is thinking about and doing that work.

Liam says,

> I think that people lack the 30,000-foot view, and actually we spend more money on not solving the problem than we do actually [solving the problem]. I just think that the distribution of healthcare spending is so misplaced in this country. We figure on trying to solve a problem that's already surpassed its scalability, and we just deal with the long-term consequences of untreated health conditions, when we could you address that, the food industry, the education industry, the early life healthcare support that's absent or grossly lacking, and the impact would be vast. But it would require multi-generational change for it to be meaningful.

Riley says,

> I mean anytime you're working in housing, you have to think through anti-racist mechanisms and policies and think about the historical exclusion of wealth from the black community and so that's a lot of the work that we do, particularly in communicating to our local government officials around funding and policies and eligibility is. Particularly analyzing those policies through an anti-racist lens and making sure that any funding that comes through isn't disproportionately being excluded from people of color or reasons why we need to be putting more funding. Like I tend to want to call it reparations a lot, but the government doesn't tend to like to use that term and so it's sort of pushing for "reparations-like" mechanisms like tax benefits and that sort of thing, so we write policy briefs around home repairs and that sort of thing.

Participants discussed the measures needed to move to anti-racism within healthcare. Participants highlighted their views of the ineffectiveness of bias training versus anti-racism education and actions like policy analysis and changes. Participants expressed their opinions that racial justice initiatives must include a broad range of actions from interpersonal opportunities to

systemic, policy, and structural changes inside and outside of healthcare to encompass the social/structural determinants of health. Participants challenged the intractability of racism and white supremacy in healthcare by proposing broad changes that are filtered through an anti-racism approach.

Summary of Section Three

The final theme Reconciling Racism and white Supremacy in Healthcare included three sub-themes 1) Evidence of Racism and white Supremacy in Healthcare; 2) Motivation for making changes: Engaging other white people in racial justice work; and 3) Future initiatives for racial justice work. Participants contextualized white supremacy and racism in healthcare in the historical and socio-political context. Participants recognized the ongoing systemic racism and white supremacy in healthcare, acknowledging the healthcare professions' reliance on a pseudo-biomedical model to explain the social and physical consequences of white supremacy and racism. Participants reconciled the need to make sense of how racism and white supremacy show up in understanding and changing inequitable outcomes and access for racialized people. They also owned the dissonance between the racism and white supremacy that can intercede in a white healthcare provider's relationship with their patient and the continued underrepresentation of Black providers. Participants shared views of racism and white supremacy in healthcare and the racial justice action needed to enact change within healthcare. Participants shared that initiatives for change must include policies and funding, and collective efforts for anti-racism. Discussion called for changes that addressed a myriad of issues relating to the structural determinants of health to include underrepresentation of Black providers, interpersonal provider relationships and policy analysis, training, and policy and funding changes.

> *I write these words to bear witness to the primacy of resistance in any situation of domination…to the strength and power that emerges from sustained resistance and the profound conviction that these forces can be healing, can protect us from dehumanization and despair.*
>
> -hooks, 1989, p. 8.

Chapter Six: Discussion & Conclusion

The aim of this study was to understand the experiences of white healthcare providers involved in racial justice work. This researcher found no other national (in the United States) or international research examining white healthcare providers experiences with racial justice work. This study sought to intentionally examine pathways of resistance to racism and white supremacy in healthcare that speak to the majoritarian narrative that claims raising issues of racism creates racism. In particular, the systems that white healthcare providers implicated in their racial justice work shed light on the far-reaching consequences of white supremacy and racism and the social circumstances of such impact healthcare. The following section Chapter Six: Discussion & Conclusion offers context for the research, the delimitations and limitations of the research and discussion of the research findings. The section ends with the implications of the research and the conclusion.

Context for the Research

Although health inequities for Black and other people of color have been documented, there is a dearth of research that examines structural and interpersonal racism in health inequities (Hicken et al. 2018). With little of the existing research examining the role that racism, white supremacy, or racial justice work plays in this phenomenon. This research examined the experiences of white healthcare providers involved in racial justice work. In the midst of the dual pandemics of COVID-19 and racism in the U.S. (Murray-Lichtman et al., 2022), there is a push to examine racism within healthcare (Hargrove, 2021). This research offered the opportunity for

allied health professions to examine their practices and strengthen their resolve to fight racism and white supremacy within social work, nursing, medicine, and health related sciences.

This chapter discusses the findings of the research and uses the theoretical lenses that guided the researcher to the research question to interpret the findings. The discussion incorporates the researcher's understanding of the approach gained from utilizing IPA, the acknowledgement of the positionality of the researcher and its impact on the analysis of the findings. Finally, the themes found in the research were interpreted through the lenses borrowed from tenets of Critical Race Theory and Critical Whiteness Studies. The researcher also explained the findings that were beyond the scope of the theories.

Analysis and Interpretation

IPA allowed this research "to go beyond quantitative restraints and feel, interpret, and understand the experience of white health care providers involved in racial justice workers (Hefferon & Ollis 2006, p. 157)." The study yielded fresh insight into racial justice efforts by white health care providers (Larkin et al., 2006). The data was analyzed with an iterative process of ongoing openness and reflexivity which facilitated the researcher remaining open to the findings that the research yielded. The following section analyzes and interprets the findings from the doctoral research study.

As discussed earlier, to address a gap in the literature around the experiences of white healthcare providers involved in racial justice work, this study sought to examine the experiences of self-identified white health care providers (doctors, nurses, social workers, and health-related scientists) involved in racial justice work. Using IPA to guide the analysis and situating the interpretation within the socio-political context of the life-world, the experiences of white heath care providers involved in racial justice work, was neither neutral nor bias-free. Instead, as the

following section will enumerate the findings raised the counter-narratives of white healthcare providers who seek to transform health inequities and disrupt the status quo of white supremacy and racism in healthcare. The discussion is organized according to the three themes found in the data and described in Chapter 5. The following section describes each theme and then presents the analysis and interpretation of that theme.

Discussion of Theme One: Omnipresence of Racism and White Supremacy

The first theme, Omnipresence of Racism and White Supremacy, presented participants' views of the pervasiveness of racism and white supremacy across systems. The three sub-themes that emerged from the data were 1) whiteness/white Supremacy is Visible and Invisible; 2) Racism Is; and 3) Racialized Trauma. The data under this theme echoed findings from the literature (Baldwin, 1985; Bell, 1992; Crenshaw et al., 1995; Du Bois, 1903; Fanon, 1952/2008; Morrison, 2019; Omi & Winant, 2019). Participants under this theme relayed the normalcy and deliberateness of the socialization into whiteness and white supremacy that they experienced and participated in. Data under this theme consistently acknowledged the systematization and institutionalization of racism and white supremacy and the trauma that it caused individually and intergenerationally for Black and other people of color.

Data emphasized the white healthcare providers' journey of coming to terms with their life-world and situating themselves within racism and white supremacy. Their evolving racial consciousness (Peller, 2016) stands in contrast to the denial of racism and white supremacy in action and institutions by most white people. Data offered a counternarrative of revisionist history highlighting the enduring impacts of historical racism and white supremacy and the contemporary harm inflicted through racism and white supremacy on Black and other people of color.

The findings detail the healthcare providers' experience of witnessing the devastating effects of racial realism and the endemic nature of racism and white supremacy within society, and the ongoing fight to dismiss the notion of a "post-racial" society (Lopez, 2010; Love & Tosolt, 2010). As Jacob points out, actually *seeing* racism and white supremacy, makes it hard to dismiss the impact on Black other racialized people. Jacob says,

> And the other thing that comes to mind is personalizing, not just abstracting, but thinking about people you care about, and thinking about the impact of racism on their lives and to try to project oneself into situations if one's white, about what it would be like, for you, for your kids…try and deepen the empathy through some kind of personal connection.

Kevin says that people must be moved, and they have to become "upset about the injustice." He goes on to say,

> You know [racial injustice] it's just not fair, right, and some [white people] probably have had specific examples, or they've seen some bad racism, you know, in their face, and that really bothered them. And some people may be just empathetic for people who are getting screwed over.

The findings implicate racism and white supremacy that occurs historically (with enduring impacts), structurally (creating upstream impediments for health/well-being), interpersonally (causing harm and lack of trust), and intrapersonally (with the internalization of white supremacy). As healthcare providers in the current study indicated, the prevalence of Black people and other people of color's distress related to structural racism and white supremacy are well documented leading to poor educational outcomes, unemployment, low income, poverty, difficulty with immigration, residential segregation, disproportionate incarceration rates, increased susceptibility to health disorders and poorer outcomes; and other chronic social

problems (Alexander, 2012; Bailey et al., 2021; Calero et al., 2017; Detlaff et al., 2020; Egede & Walker, 2020; Elkassem & Murray-Lichtman, 2022; Fontenot et al., 2018; Hatch & Dohrenwend, 2007; Khazanchi et al., 2020; Maguire-Jack et al., 2020; Murray-Lichtman et al., 2022a; Sacks & Murphy, 2018; Slopen et al., 2016; Williams & Collins, 2001).

The data indicts the visibility of racism and white supremacy and the invisible system that undergirds racism and white supremacy. As the discussion of theme two will further elucidate, data under this theme determined that the socio-political location of the observer could obscure or reveal the presence of racism and white supremacy. Data of participants identifying as white mothers often captured best the "awakening" to the depravity of racism and white supremacy coming because of their wish to offer Black and other children of color and their children an opportunity for a different future. Mary's comment exemplifies this.

> I think part of that is my willingness to take off my blinders. I think as a white person, I have to consciously think about race. I have to consciously *choose* to think about it. I think having kids has been part of that, it's like I don't want my kids to have to unlearn racism. I want them to grow up anti-racist.

The notion of realizing that white children's destiny and potential oppression (and *their* [white participant's] destiny and legacy) is inextricably linked to racism and white supremacy is not surprising. Historical research of white women's suffrage and feminist movements and the embrace or dismissal of the plight of Black women, men, children, and other people of color as it was most expedient provide examples of this phenomenon (Collins, 2015; Newman, 1999; Wells-Barnett, 2002). This theme illuminated the epistemology of ignorance (Mills, 1997), with most white healthcare providers *awakening* to racism and white supremacy. Ailene says, "I really think that the thing that prompted me most was those two black women students when

Trump was being elected, saying, they were worried. That like hit me like a ton of bricks.” Liam says,

> …I think that certainly the events of 2020 [COVID-19 disparities and public murder of George Floyd by police officer]. I think increased the intensity of our engagement. Just all of the awful things that continue to occur in terms of police brutality towards Black people in this country.

As theme two demonstrated, because participants acknowledge the “white immunity” that white supremacy grants them, and from which they continue to benefit, (Applebaum, 2006, 2010, 2015; Matias et al., 2014; Cabrero, 2017; Leonardo, 2004) does not immediately make them anti-racist. Emily’s comment below exemplifies this.

> I’ve noticed as a white person it's taken me some time to foster the lens of seeing the structural racism more clearly. I’ve had to teach myself to look for that and notice that. Because I’m so imbued in whiteness having grown up in whiteness and accepting a certain thing is the norm and assuming that no one, no system would be set up to disadvantage other people.

Some participants still held firmly to incrementalistic approaches to anti-racism and believed that their ascent through the ranks (without disruption to white supremacy) was inevitable, and upon ascension, they could assume a more frontal anti-racism approach. Others apologetically conceded that a challenge to *de jure* racism in their area of healthcare might jeopardize other aspects of their work and mobility. Still, others had specific “carve-outs” for their anti-racism work and could put it down or pick it up depending on the spatial and politically associated risks. This gets at Fanon’s (1963) idea of the reality of a continuum of coloniality, whereby there is no vision outside of the colonized and the colonizer, even among would-be anti-racist “activists.”

This view places the sovereignty of whiteness as uninterrupted by some of the study participants espousing this vision of "racial justice work;" most regrettably, it places their view of the historical and political discourse of domination as always understood (Alvaro, 2012).

Data under this theme demonstrated some white healthcare providers' professional research and findings of the traumatic effect of racism on Black children and adults. Participants blamed structural racism and white supremacy as underlying factors representing findings from the extant literature (Bailey et al., 2021; Fontenot et al., 2018; Hatch & Dohrenwoood, 2007; Maguire-Jack et al., 2020; Sacks & Murphey, 2018; Slopen et al., 2016; Williams & Collins, 2001). Findings from the present research echoed evidence from a recent multi-site longitudinal study highlighting the traumatic effects of racism on Black people's brains. "Toxic stress levels" associated with structural racism (e.g., poverty and adverse childhood events [ACES]) are found to cause lifelong negative consequences for Black people's health (Harnett et al., 2023; McFarling, 2023). Data from healthcare providers in the current study concurred with prior research finding higher prevalence of posttraumatic stress disorder (PTSD) in Black people (Roberts et al., 2011). Data from the current study also pointed to the disproportionate recent events such as brutal police killings of Black people and the inequities in death and sickness due to COVID-19 impacting Black and other communities of color as having detrimental health effects. Recent research examining violence against racialized people and the increased worry, concern, and symptoms of PTSD among mothers concerned with the welfare and safety of their Black children (Printz Pereira et al., 2023) and racial discrimination's influence on PTSD development in Black people (Bird et al., 2021) agree with the current study's findings of the increased anxiety, stress, fear, and negative health consequences that racism causes in the lives of Black patients.

Concurrent with other findings regarding the intractability of racism and white supremacy in healthcare and the accompanying distress on the Black body (Adjei, 2018; Feagin & Benefield, 2014; Giwa, 2018; Medlock et al., 2017), white healthcare providers involved in racial justice work, *experience* and come to *their understanding* of the *impact of* and *their role in* racism and white supremacy through their own daily (colleague and patient) interactions, research outcomes, and personal lived experience in relation to the injustice in healthcare and their failures to achieve justice. Their "counter-accounts" (Crenshaw et al., 1995, p xiii) are not neutral, objective, or detached rather they subvert the dominant narrative of the causes of health inequities. Their accounts interrogate and problematize the pseudoscience, depersonalization, and detachment of healthcare outcomes and interactions (Metzl & Roberts 2014; Roberts, 1995, 10997, 2011, 2017; Washington, 2006); instead, their opposition to systemic racism and white supremacy in healthcare place them in the "outgroups…[a] group whose consciousness is other than that of the dominant one….and subvert that ingroup reality" (Delgado, 1989, pp. 2412-2413). Their counter-narratives demonstrate that health inequities allow "'no exit'---no scholarly perch outside the social dynamics of racial power from which merely to observe and analyze (Crenshaw et al., 1995, p xiii)."

Discussion of Theme Two: Anti-Racism (Racial Justice Worker) Identity Development

The second theme, Anti-racism (racial justice worker) Identity Development, describes the process participants experienced during their journey to becoming anti-racist and a "racial justice worker." The theme consisted of three sub-themes 1) Recognizing and Bearing Witness: Reconciling personal convictions of "non-racism;" 2) Intrapersonal Processes for Identifying and Embracing Racial Justice Work; 3) Evolution and Phases of Anti-racism Identity Development. Data in this theme highlighted participants' impression of the continual process of "becoming" anti-racist. Some participants' data echoed declarations of whiteness (Ahmed, 2004, 2006), and the "good" white person/helper complicit in white supremacy (Adjei, 2013; Applebaum, 2010; Badwall, 2014; Heron, 2007; McFarling, 2021; Wright, 1919; Yancy, 2014). Miller and Garran (2007) acknowledge that one danger of the inability to see racism and white supremacy [or oneself implicated in white supremacy and its existence in your own house] is "that many people exist in homogenous environments where it is easy to mistake mirrors for windows (p. 35)." This reflects the thought leaders who depicted whiteness as having the ability to "impale" white people (Baldwin, 1985) and happening behind a veil through which Black people had no difficulty seeing, but those partakers of whiteness often thought obfuscated their complicity (Du Bois, 1920).

> Well, it's hard; right, because like I said, if you don't say anything, you're complicit. And so, to a degree, I guess I've been complicit in a lot of situations, and you know I haven't made a big fuss ever or made a big fight. That's what you also see with this DEI group. You know they have their meetings, but they don't make a big fight about anything, which is probably why it's ineffective.

The next participant’s comment also reveals how detrimental white supremacy can be to racial justice work because it allows inhabitants of whiteness to minimize and incrementalize change and sustains.

> You know, I was that, you know, the white moderate that Dr. King talked about, you know, the most dangerous for progress and dismantling injustice and that was, that was totally me, and I’m glad that I can see that for what it is, but there was really a huge feeling of rage and also helplessness and guilt with that.

The data mirrored the extant literature that white healthcare providers needed to get know themselves in addition to seeing racism. They needed to come to understand their relationship with white supremacy (Perry & Shotwell, 2009). The data agreed with prior research of the socialization into whiteness and the study participants understanding of themselves as innocent, good helpers. Many participants discussed how they needed to acknowledge this and understand it along their journey of racial justice work (Frankenberg, 1993; Hagerman, 2018; Jones, 2019; McRae, 2018). Some participants also acknowledged what felt like a push or drive to be involved in racial justice work similar to the literature’s recognition of the moral impetus that some people feel to make anti-racism changes (Warren, 2010).

As Remi’s comment below illuminates, the data revealed the tension between *what about-isms, white suffering, and the* denial/silence about racial injustice.

> It's like the very traditional white ’guilt--shame ‘model of like, oh, how can I say I’m doing anti-racist work? How can I say I’m doing racial justice work if this person told me that I said the wrong thing? ... I’m not meant to do it; like that's the reaction of like the ‘flounce out of racial justice spaces’ because you got called in,.... and it is just as harmful as never going to a racial justice space.

Along with the *discomfort* of having to come to terms with being called to recognize their enactment of whiteness, data revealed that in the early stages of their racial justice journey, some white healthcare providers employed colorblind liberalism within their interpretation of intersectional oppression. Data demonstrated the imperceptible ways that white supremacy was activated in individuals and in society through its ties to other forms of oppression, forming *invisible* bonds such that a pull to dismantle one is often viewed as a threat to the whole of white supremacy. Participants observed that the connections and threads between white supremacy and other "-isms" including, but not limited to, capitalism, sexism, homophobia, Christianity, coloniality, ableism, and patriarchy were interlaced with and strengthened white supremacy.

Participants struggled to resist equating their identity-based oppression (e.g., disability, gender, religious identity) with the oppression based on racism and white supremacy. Some participants had taken the view that we must move beyond the "binary" when discussing issues of race and racism and that approaching the discussion through the lens of anti-Black racism sets the stage for the hierarchy of oppressions (Fellows, & Razack, 1998; Delgado & Stefancic, 2001). The next participant's comments demonstrate the struggle some participants had along their journey to equate their suffering with the racism and white supremacy experienced by Black people. Their denial of the nature of white supremacy and its dependence on *anti-Black* racism obscured their ability to see how white supremacy utilized the "what about-isms" to instigate white fear, anger, grievances, bigotry, and victimhood. They perceived their own bodies as bearing the brunt of an "*-ism"* and equalized their suffering with that of those experiencing racism. They were able to understand the oppression of their intersectional identities but neglected the centrality of race to intersectionality. This "whitening of intersectionality" (Bilge,

2013, p. 405) speaks to the repudiation of the integral lens of race in white feminist thinking. The participants' entanglement with white supremacy caused them to deny the permanency of racism and the function of Blackness in the white imagination (Bell, 1992/2018; Morrison, 2019).

> Yeah, you know, I talked a little bit about being Jewish, and I've brought up, you know, being queer, non-binary, neurodivergent, disabled. So, I think [my social identities] it's shaped negatively; some of my early attempts at racial justice work because I would get caught up so much and [think] 'but, I'm oppressed too as a ... 'blank.'

Using the lens of racial realism and the continuing differential racialization that admits some bodies into whiteness and ascribes to other bodies Blackness depending on political, socio-geographic, and spatial differences invites closer scrutiny of the "hierarchy of oppressions" and meritocracy discussions. The enduring manifesto of white supremacy is the distancing from the spatiality of Blackness—making work against anti-Black racism *strange* and *unnecessary,* and the white habitus (Bilge, 2013; Frankenburg, 1993) *coveted* and *imbued with permanency*. Prior research is clear: the closer a body is to whiteness, the more power and immunity or privilege placed on that body and the closer a body is to Blackness, the more disadvantage (Adjei, 2013; Baldwin, 1985; Cabrera, 2017; Crenshaw et al., 2021b; Fanon, 1963; Kimmel & Ferber, 2017). This phenomenon is supported by research and literature from across social and material domains (Bailey et al., 2021; Feagin & Ducey, 2019; Roithmayr, 2014; Zuberi, 2001). According to the data, as participants progressed in the development of their racial justice journey, they began to acknowledge the pervasiveness of racism and white supremacy and the interlocking oppression with intersecting identities (e.g., race, class, gender, sexuality, religion, age, ability) across racialized groups that impacted access and outcomes. The extant literature documents interlocking oppressions and the pernicious interplay of racism and white supremacy (Bell, 2018;

Collins, 2015; hooks, 2015; Wells-Barnett, 2002; Crenshaw, 1991). The data demonstrated that for the participants who foregrounded racial realism, intersectionality became a critical praxis (Collins, 2015) that enabled them to understand how a body's proximity to Blackness or the embodiment of Blackness directly impacts the experience of oppression faced via an intersecting identity (Adjei, 2013).

For example, Remi moves from equating her disability with racism to acknowledging that Black disabled people are the most likely to be killed by police and least likely to receive disability services. Remi's assessment aligns with the data regarding race and disability (Calero et al., 2017; Schalk, 2022). The interlocking oppression of race and disability often has negative consequences in every aspect of life for racialized people, including but not limited to education, healthcare treatment, immigration, employment, and criminal legal involvement (Alexander, 2012; Annamma et al., 2018; Calero et al., 2017; Delgado & Stefancic, 2007; Henne & Shah, 2015; Murray-Lichtman et al., 2022b; Perez, 2019). Likewise, Jacob grew in his understanding of the interplay between his Jewish religious identity through which he and his family experienced oppression (Kimmel & Ferber, 2017) and his embodiment of whiteness. Jacob, Kevin, and Remi self-identified as Jewish, and as they progressed in their anti-racism identity development, each came to see the hegemonic influence of whiteness and white supremacy that they could not disembody. Participants in more advanced stages of their anti-racism identity development were able to see the *wretched* (Fanon, 1963) and beyond the veil (DuBois, 1920) and their embodiment of the hegemony of white supremacy. Concurring with prior research, data revealed that white healthcare providers involved in racial justice work realized that they could not get rid of their white immunity (Cabrera, 2017) but must continuously struggle to use their

epidermalized embodiment of white supremacy (Adjei, 2018; DuBois, 1903, 1920; Fanon, 1952, 1963; Yancy, 2017) as weaponry in the battle for racial justice.

Participants further along in their journey of anti-racism identity development and racial justice work described moving beyond non-racism and performative actions and being willing to experience the double-edged sword of whiteness (Baldwin, 1962, 1984) and white anguish that called into question their "greatness" and power in anti-racism spaces (Du Bois, 1920, 1935; Fanon, 1952). Participants at advanced stages of their anti-racism identity development had embraced actions that interrogated and problematized white supremacy inside and outside themselves. The data echoed previous literature suggesting that to acknowledge and unseat personal culpability in racism and white supremacy, there must be continuous self-reflection (Heron, 2005) but also action (Murray-Lichtman & Elkassem, 2021) in the form of daily acts to disrupt structures that make domination possible (Leonardo, 2004).

Data under this theme also emphasized white healthcare providers' interest convergence, material determinism, and color-blind liberalism. It demonstrated the continuous struggle that white healthcare providers involved in racial justice work faced with their possessive investment in whiteness and the imbued power and privilege of whiteness and white supremacy. The findings mark the geopolitical, physical, material, and psychic socialization to whiteness as a system of preferences, perceptions, emotions, and white over ascendancy that participants had to reconcile with racial justice efforts and their anti-racism identity development. This data concurs with prior literature indicating that white people involved in racial justice work must see racism and white supremacy but must also come to see *themselves* within this system (Case, 2012; Perry & Shotwell, 2009; Selvanathan et al., 2017; Ulug & Tropp, 2021).

This theme's data pointed to the interest convergence and material determinism blatantly exemplified during the COVID-19 pandemic. The data coincides with prior research in this area. For instance, in social work, prior research documented the evidence of social work aligning with de jure racism and white supremacy while researchers and those in power espoused social justice. Some participants in the research raised the dilemma of social work's historical practice and current practice of marginalizing racialized voices while idealizing white epistemologies and white agents in social work. This reflects the literature; for example, leaders like Mary Richmond and Jane Addams are held up as icons within the profession without accurate representation of their roles in white supremacy (Boles et al., 2016; Hamington, 2005; Wright, 1919; Wright et al., 2021). Other participants noted, in medicine, the homage paid to Martin Sims (father of gynecology), who now faces more pronounced scrutiny for the atrocities and depravity of his medical research and experimentation on Black female bodies (Owens, 2017; Washington, 2009). Boles et al. (2016) and Hamington (2005) found that while Jane Addams advocated for disadvantaged people, she also sided with whiteness when it was expedient for her career. Additionally, Mary Richmond's embrace of science and the medical model and quest for professional validation is seen as unfaithful and an abandonment of the mission of social work for social justice (Specht & Courtney, 1995). Data from the study reflected, as the literature demonstrates with the examples from social work and medicine, that acknowledging the dual consciousness that evolved from these historical practices can assist social work and other healthcare professions in identifying how white supremacy still characterizes the professions, from their healthcare practices, humanitarian aid, to public service today (Adjei & Minka, 2018; Allen, 2006; Bailey et al., 2021; Bell, 2020; Brice & McLane-Davison, 2020; Briggs et al., 2018; Bryant & Kolivoski, 2021; Carten, 2016; Corley & Young, 2018; Dominelli, 1997; Gosine &

Pon, 2011; Goyal et al., 2015; Goyal et al., 2020; Gregory, 2020, 2021; Hardeman et al., 2016 a, b; Hardeman et al., 2020; Hartry, 2021; Hassouneh, 2006; Ioakimidis & Trimikliniotis, 2020; James, 2016; Jeffery, 2005; Puzan, 2003; Seltzer & Haldar, 2015).

> I think that one of the things that I noticed is this, you know the sort of more recent push for diversity, equity, and inclusion, which is great. But it's like, you know, putting a dusting of primer, on top of like a gaping hole in a in a wall, you know, like a wall with a hole that goes from an internal wall to like the outside of the house, and then just saying well we're just going to paint over this.

As mentioned above, participants in the study also noted that there was interest convergence and material determinism via an increased interest in diversity, equity, and inclusion efforts in healthcare spaces. This reflects what is found in the literature. During the dual pandemics of racism and COVID-19, there were widespread appeals to social work (Abrams & Detlaff, 2020; Detlaff, 2020; Cherry, 2020, CSWE, 2021; CASWE, 2020; NASW, 2020), medicine (Bailey et al., 2021; Hardeman et al., 2020; Hargrove, 2021; Johnson, 2021), and nursing (Bell, 2020) to address racism and white supremacy. These calls were not new; Black social work, medical, and nursing professionals (and allies) have appealed for decades to address the impact of whiteness and the entrenchment of racism in the profession (Allen, 2006; Hassouneh et al., 2012; Holosko et al., 2018; Metzl & Hansen, 2014; Puzan, 2003; Shannon, 1970). As the following participant noted the calls for racial justice in healthcare are often met with performative statements (Elkassem & Murray-Lichtman, 2022).

> Yeah, they make statements to the department over email, "so sad that this happened," and you know, "We can't accept racism and violence." But again, the hiring hasn't changed and when I say 150 in our department, that's maybe an underestimate it might be

> closer to 200 people, But I guarantee there's less than 8 African Americans [doctors or nurses] which doesn't make any sense, unless you're specifically scaring them off, or not hiring them, and or they just don't want to bother to apply.

Participants in this study noted that these DEI statements often lacked the substantive efforts and policy changes needed to bring about change. Most participants also noted that even their "efforts" for racial justice enhanced their career and with only a few rare exceptions their racial justice efforts had rarely caused them any harm or unease. Data under this theme reflected the widespread interest convergence and material determinism (Bell, 1980) that enticed white researchers and others to seek a piece of the "health equity" work during the dual pandemics of racism and COVID-19 (Murray-Lichtman et al., 2022a). The literature demonstrates that during this period, white researchers aligned themselves with health equity topics to get grant funding and more publications. Black researchers had been doing the work in the past and it was not deemed fundable. Some calling the phenomenon, the "colonization" of health equity research (Arling, 2021b). Data also called into question the "funders," "decision makers," and reviewers/editors who granted funding and published new white health equity researchers who swooped in to do the research. Study data called for more representation of Black researchers, decision-makers, and reviewers/editors in funding entities and journals to disrupt racism and white supremacy in research and scholarship. While others may have initiated their efforts during this period to have a part in being a "good" white helper (Heron, 2007) or to feel good that racism and white supremacy were outside of them (Ahmed, 2004; Sullivan, 2014). This voyeuristic approach and extracting from the suffering of communities is reflected in the literature (Murray-Lichtman & Elkassem, 2021).

Although some white healthcare providers involved in racial justice work had not progressed far in their anti-racism identity development, there were those who had. Data revealed that white healthcare providers who had advanced in their anti-racism identity development often had reconfigured their white habitus or racial habitus and integrated their social and spatial locations to include literature, voices, and bodies of color in their habitus (Bilge, 2013; Bonilla-Silva, 2018) long before the dual pandemics.

They had to rid themselves of colorblind liberalism and their possessive investment in whiteness in an intentional way that required continual active agency and investment in the choices that they make (Ignatiev, 1995). For instance, data revealed that in addition to Riley's anti-racism efforts through medical care, they work through community engagement to redress racist structural issues like inadequate housing and disproportionate taxes and ordinances that impact health and would otherwise lead to gentrification. They further discuss that their social circle is enhanced by professional and personal Black friends whom they engage with in the struggle for racial justice in healthcare and in the community. Data indicates that, like Riley, other participants were able to use their whiteness as property to deliberately push open doors to extend access to the material, psychological, social, legal, and political benefits for Black and other people of color (Du Bois, 1935; Harris, 1993).

Discussion of Theme Three: Reconciling Racism and white Supremacy in Healthcare

The final theme Reconciling Racism and white Supremacy in Healthcare included three sub-themes 1) Evidence of Racism and white Supremacy in Healthcare; 2) Motivation for making changes: Engaging other white people in racial justice work; and 3) Future initiatives for racial justice work. This theme came full circle emphasizing the presence of racism and white supremacy in healthcare. Participants identified their personal areas of advocacy and research,

and the historical evidence of racism and white supremacy that continues to impact healthcare (fear of vaccines and seeking healthcare treatment) or manifest in healthcare (provider and systemic racism that impacts health outcomes). These findings of racism and white supremacy in healthcare that cause poorer outcomes and increased mortality for people of color reflect the work of earlier and more recent Black activists and scholars (Nelson, 2011; Washington, 2009).

The data under this theme echoes the evidence in social work supporting the lived experience of white supremacy within social work (Abrams & Detlaff, 2020; Adjei & Minka, 2018; Corley & Young, 2018; Detlaff, 2020; Detlaff et al., 2020; Giwa & Pon, 2019; Davis, 2016; Holosko et al., 2018; Jeffery, 2005; Jeyasingham 2012; McMahon & Meares, 1992; Razack & Jeffery, 2002; Shaikh, 2012). Unsurprisingly, the existence of white supremacy and racism, encompasses both the presence of white supremacy and racism and the denial of white supremacy and racism (Abrams & Detlaff, 2020; Adjei, 2013; Badwall, 2014; Banks, 2018; Briggs, et al., 2014; Elkassem & Murray-Lichtman, 2022; Murray-Lichtman et al., 2022a; Murray-Lichtman & Elkassem, 2021). The evidence also exists in medicine (Banks et al., 2008; Banks et al., 2009; Laws, 2021; Medlock et al., 2017; Medlock et al., 2019; Metzl & Hansen, 2014; Metzl & Roberts, 2014; Zambrana, 2017), nursing (Allen, 2006; Hassouneh, 2012; Puzan, 2003) and health-related sciences (Chang et al., 2016). The consistencies validate the temporal and spatial ability of whiteness and white supremacy to self-perpetuate across time and place and healthcare disciplines (Hughey, 2016).

Data in this theme highlighted the urgent need to address the underrepresentation of Black providers and systemic issues with service provision in the healthcare field. Participants called for a push for more Black and other people of color to enter the healthcare field. Findings of the study demonstrated a need for more holistic admissions process and supports for

underrepresented students and professionals within the field. Data revealed that there was a connection between the representation of Black and other people of color in healthcare and the ability to attract more underrepresented students and practitioners. This echoes the research around the need for underrepresented healthcare providers and the strategies for success of underrepresented students and providers in healthcare (Alegria et al., 2019; Hassouneh et al., 2014; Hassouneh et al., 2012; Zambrana et al., 2017). This participant's comments sum up the need for racial justice in this area.

> Specifically, in healthcare [initiatives to address racial injustice] first of all far and away, we have to recruit more non-white physicians into medicine. It is just, it is appalling that there are so few non-white students in the pipeline, and you know a lot of medical schools have just begun the kind of early steps of remedying that. But we know even empirically, we know that non-white physicians often will practice in the communities they came from. They [non-white physicians] also are role models to patients who are maybe young children, for example, who grow up seeing, you know, oh, I have a pediatrician who is a native American or who's Black and I am native American or Black and I could be this when I grow up. So, it's really important to get that cycle started.

Consequentially white supremacy in healthcare often means underrepresentation of Black providers and adverse outcomes for Black people. Participants in the study cautioned that the underrepresentation of Black healthcare providers continues to be a significant issue that impacts maternal and child health and community health, especially for Black people. Data from the study indicated that inequitable treatment of Black patients by white healthcare practitioners included a lack of thorough assessment of presenting patient concerns, dismissing patients' presenting concerns due to disbelief, nonexistent to ineffective pain treatment due to racist

ideologies of "drug-seeking" associations with Black patients; diminished array of treatment options offered due to no or inappropriate screening or provider "assumptions" based on racist generalizations of Black patients about the suitability of treatment and *likelihood* of adherence to treatment recommendations; stereotyped labels of "non-compliance," or "angry" Black patients when faced with Black patients' questioning or complaints about healthcare treatment; dismissing patients' power/ability and agency to complain or the consequences to them as a white provider; overdiagnosis or underdiagnosis of certain disorders; and increased poor outcomes or mortality due to inadequate to nonexistent treatment. White healthcare providers involved in racial justice work were able to *see* their colleagues' interpersonal racist behaviors and systemic racism and white supremacy shedding light from an insider perspective that is rarely reflected in the extant literature even as disparate outcome data is reported. White healthcare providers' calls for advancing racial justice and decreasing health inequities for Black people in healthcare by increasing the presence of underrepresented Black healthcare professionals coincides with the extant literature (Cunningham, 2020; Effland et al., 2020; Greenwood et al., 2020).

The findings of the current study are supported by NASW's (2021) findings of an overdiagnosis of certain mental health disorders that carry more stigma (i.e., schizophrenia, conduct disorder), and required medications with more severe adverse side effects, and poorer outcomes and underdiagnosis of less stigmatizing mood disorders in Black patients despite similar symptomology. The current study's findings also concur with Snyder et al.'s (2023) research analyzing a ten-year period of Black healthcare worker's representation in the community. "Results indicated that greater Black workforce representation was associated with higher life expectancy and was inversely associated with all-cause Black mortality and mortality

rate disparities between Black and White individuals (Snyder et al., 2023, p. 1)." In addition to Snyder et al.'s, (2023) analysis, likewise, maternal and child health among Black people benefits from the care of a Black physician (Owens & Fett, 2019).

Findings from the study of participants' perceptions of the challenges to recruitment as professionals and admissions as students into healthcare reveal systemic color blindness mirroring research from Crenshaw et al. (2021a). Like Crenshaw et al., white healthcare providers, involved in racial justice work called for analyses that examine current practices and policies that remove exclusionary practices of the past that are still being reproduced in recruitment and admission despite anti-discrimination policies and trainings (Crenshaw et al., 2021a).

Data in the current study challenged the pseudoscience of the past, specifically in relation to Black people's health. Data indicated that structural racism and racism and white supremacy in healthcare were responsible for the health outcomes for Black and other people of color. This reflects recent research determining that structural racism indicators (i.e., low income and adversity) are toxic stressors and were found to be the factor that influenced brain development and aging in a negative way among Black people (Harnett et al., 2023; McFarling, 2023). Research indicated that pseudoscientific reports from psychiatry's long search to equate a biological indicator of "race" to brain differences was again debunked (Harnett et al., 2023; McFarling, 2023). The data from healthcare providers in the current study also discussed the inequitable treatment of pain, the discrepancies in the treatment of pregnant Black women and children and pain management for Black people. Data also indicated structural racism as the contributing factor to PTSD and chronic health and mental health disorders. Data from the current study also agreed with prior research indicating that Black people and other people of

color were less likely to seek treatment for PTSD (Roberts et al., 2011). Overall, as indicated in the findings of this study, research finds that structural and systemic racism cause racialized trauma, negative health consequences, and poor health outcomes for Black people (Bailey et al., 2021; Banaji et al., 2021; Giwa, 2018; Metzl & Hansen, 2014; Metzl & Roberts, 2014). The following participants sum up the experiences that some Black patients face with white healthcare providers.

> …and "by the time they get to providers they are already labeled." Loretta says, "You surmount all of those barriers and then you get in the office to have typically a white practitioner, who does not take your health concerns as they are, and so we often perpetuate that mistrust, if we don't work actively to earn that trust."

While participants problematized the systemic and interpersonal failures due to racism and white supremacy, data from the research also revealed that some participants had progressed to a point in their anti-racism identity development where they wanted to engage other white people in their efforts for racial justice. Data demonstrated that this became an ongoing priority when they encountered others with an interest in making systemic changes or engaging with patients differently. Participants would often engage in facilitating anti-racism or equity training and join committees dedicated to health equity work. Data revealed that some participants were very unsatisfied with the slow pace of change and an incremental approach to anti-racism efforts.

Participants wanted future initiatives in healthcare to move from "bias trainings" to anti-racism training in the explicit and implicit curriculums taught in the professional schools and in practice settings. The literature reflects study participants' conclusions that bias trainings rely on individualistic notions of harm and do not indict the systemic and structural racism and white supremacy present in healthcare (Green & Hagiwara, 2020). Additionally, study participants that

pushed forward with racial justice work despite the discomfort they experienced align with the calls to demonstrate their allyship in ways that might shed light on white supremacy and advance anti-racism (Mensah, 2020).

Integration of the Demographic Survey Findings

This researcher was interested to see if findings in the literature regarding exposure to racism (and anti-racism work), religious activity, or childhood experiences might influence or impact participation in racial justice work for the participants. While this information is not generalizable beyond study participants, this study does support the findings that exposure to racism's impact on people of color does provoke participation in anti-racist activities (Selvanathan et al., 2017; Ulog & Tropp, 2021). Kevin and Jacob, with their childhood exposure to anti-racism, are good examples of how this phenomenon presented in the data and coincides with the literature findings that childhood exposure to anti-racism may be associated with future anti-racism mindsets (Bussey, 2021). Likewise, relationships with people of color inspiring participation in racial justice work (Selvanathan et al., 2017) was positively correlated with anti-racism efforts in the current study and in the literature. Mary, Lorreta, Riley, and Remi are examples of how relationships with Black people changed participants perceptions and demonstrated the participants' growth to an intolerability of racism. As demonstrated in the extant literature, socioeconomic status in childhood did not seem to predict or correlate with racial justice work in adulthood (Frakenberg, 1993; Hagerman, 2018), which may have to do with the socialization to whiteness in every area of society. The demographic survey findings are limited to the current survey; however, the findings from the demographic survey suggest opportunities for future research.

Employing Counter-Narratives: white Healthcare Workers' Racial Justice Work

As demonstrated in the discussion of the findings from the research examining the experience of white health care providers involved in racial justice work, the urgency for tackling heath inequities cannot be overstated. This has been a pressing issue for over a century and will continue to undermine the health and wellness of Black and other people of color without a full-frontal assault on racism and white supremacy in healthcare. Du Bois (1899, 1906) assessed that the most challenging part of the social problem of Black people's health was the "peculiar attitude" toward the well-being of Black people---Black people's suffering is viewed with such "peculiar indifference (p. 242)." The persistence of white supremacy established by the racial contract undermines the interest of all in society (McGhee, 2021) while providing a material benefit and psychological safety net for people socially constructed as white (Du Bois, 1935). According to Charles Mills (1997), "all whites are beneficiaries of the Contract, though some are not signatories to it (p.11)." As a society, our healthcare access and outcomes are filtered through white supremacy, and as the stark prevalence of COVID-19 and the unnecessary deaths reminded society, we *all* pay the price (Metzl, 2019).

The white healthcare providers in this research are motivated to use their power and privilege to fight health inequities. Their desires to disrupt white supremacy and racism in healthcare underscored the heart of this research to understand the experiences of white healthcare providers' racial justice work. These findings present an opportunity to learn more about racial justice development and how white healthcare providers become engaged in anti-racism efforts. Additionally, the findings offer an inside look through the eyes of white healthcare providers at how racism and white supremacy are enacted in healthcare. This data sits

alongside the experiences and voices of Black and other people of color who are impacted and harmed by these enactments.

While some in the study had outpaced others in terms of their engagement with racial justice work, most of these white healthcare providers work against the grain and not in the interest of maintaining their claim to white supremacy. The self-perpetuating nature of racism and white supremacy demands that they are always vigilant, self-reflexive, and active laborers against whiteness. Their experiences and racial justice actions demonstrate a path forward in the fight against racial injustice and health inequities. As beneficiaries of white supremacy, they are uniquely suited to make changes that dislodge white hegemony in healthcare, impact health inequities, and open the door for racialized bodies in healthcare.

Implications of the Study

The findings of this study are significant to the advancement of anti-racism in social work and the provision of healthcare. The study has far-ranging implications for the health and well-being of all people and strategies to attack health inequities among Black people. The current resurgence of "white rage" masks our society's thinly veiled desires to maintain white supremacy (Abrams & Detlaff, 2021; Crenshaw, 2021). CRT and CWS debunk the notion that individual non-racist proclamations, race-neutral language, or ahistorical accounts make racism, white supremacy, and the resulting health inequities disappear. Healthcare professions (social work, nursing, medicine, and health sciences) all espouse anti-racism statements. Nevertheless, health inequities for racialized people remain entrenched and continue to impact Black people disproportionately. The counter-narratives of white healthcare providers in this research call for the disruption of the inequitable treatment of Black and other people of color.

The study highlights the structural racism in healthcare that excludes racialized people as healthcare providers and racialized bodies as those deserving optimal healthcare access, treatment, and outcomes. The findings provide the potential for systemic transformation and have implications for healthcare leadership and policy. The findings also serve as a roadmap for other healthcare providers to dismantle oppressive practices and engage in racial justice. White healthcare providers name the following micro, mezzo, and macro level anti-racism changes in healthcare: healthcare education (incorporate ongoing anti-racism interventions/trainings against the enactment and impact of racism and white supremacy in healthcare policy and practice accompanied by strategies aimed at ongoing evaluation of the intervention; healthcare policies (incorporate and evaluate strategies to address the underrepresentation and under-resourcing of Black healthcare providers and issues that impact their matriculation and presence in healthcare academies, leadership positions, funded research, and scholarly publications); healthcare practices (incorporate strategies to evaluate and intervene in white supremacy and racism in interpersonal and systemic healthcare interactions with Black and other people of color); healthcare research (incorporate and evaluate strategies to mitigate white supremacy and racism in reviewing decisions *and* funding allocations for research that advances issues impacting the health of Black people and other people of color); and healthcare publications (incorporate inclusive and equitable strategies to evaluate and intervene against white supremacy and racism in calls for publications, reviewer processes and publication decisions). Findings also implicate structural changes that specifically address the admission of underrepresented bodies [Black scholars, researchers, providers] into academic spaces, leadership, and healthcare provision positions. The findings of this research are essential to healthcare, specifically social work, whose ethics should inform anti-racism action.

Delimitations and Limitations of the Research

There are delimitations and limitations to this research. One potential limitation is the research ethics board's stipulations that limited the researcher's ability to reach out directly to white healthcare providers involved in racial justice work. This limitation could have caused the attrition that impacted my final sample size. Also, the population being researched, "healthcare providers," and the time period of the research, during the resurgence of COVID-19, could have impacted the availability of healthcare providers to participate due to an increased demand on their time during the health crisis are other potential limitations. A potential delimitation also could have been the virtual nature of the interviews which could have inhibited certain responses that participants may have shared if the interviews were conducted in person. The researcher chose to include doctors, nurses, social workers, and other health-related scientists; a potential limitation is the small sample size of each group. Another delimitation of the study is the stipulation of anonymity which disallowed more thorough demographic details of the participants, given the prolific nature and visibility of some of their work.

Conclusion

This dissertation presents the phenomenological investigation into the experiences of white healthcare providers involved in racial justice work. Chapters one through four situate the discussion within social work and provide a literature review of racism, white supremacy in healthcare, and the experiences of white healthcare providers involved in racial justice work. They established the context for the conceptualization of the research, including the researcher's social location and philosophical assumptions. The discussion explained the critical theories, CRT and CWS, which led to the research. It included a description of the history of phenomenology and an overview of IPA's suitability for the theoretical framework and research

topic. The dissertation included an in-depth description of the research design, including sample recruitment, data collection, and analysis methods as applied to the research. Finally, chapters five, findings, and six, discussion, demonstrated the need for more research on white people in healthcare who want to be involved in racial justice work.

Overall, the health inequities and the entrenchment of racism and white supremacy in healthcare described by white healthcare providers involved in racial justice work echo the experiences that have been reported for years by Black and other people of color. Historically, race workers, the Black people who took on the work to improve the lives of Black and other people of color, were occasionally joined by white racial justice workers. These white racial justice workers are rarely acknowledged and certainly not esteemed for their fight against white supremacy, yet some gave their lives for the mission of racial justice. Knowledge production with goals for the emancipation of Black people has a history of facing suppression, oppression, and domination by perpetrators of white supremacy. Unlike race workers in the past, perhaps, the threat of physical harm seems less imminent, but the erasure and marginalization of voices that speak truth to power is equally silencing. For many white racial justice workers',
the *ongoing* (personal and systemic) *struggle* against the enactment of white supremacy and racism *becomes a sense of purpose,* and the *benefits of the collective* work with Black and other white people against white supremacy bring *personal satisfaction* and a *sense of community*. The experience of white healthcare providers working against their interest in white supremacy to enact anti-racism and achieve health equity for Black and Brown people is a crucial step to reaching racial justice.

The urgency for white healthcare providers to partner with Black and other people of color to upend the status quo and to disrupt racism and white supremacy in healthcare has never

been more dire. The insider voice produced by white healthcare providers' accounts of their racial justice work bears witness to racism and white supremacy in healthcare. It aids in the fight against systems that deny the lethality of the health inequities caused by systemic racism and white supremacy in healthcare. This research points to a path forward for healthcare providers like social workers, nurses, and doctors across social identities and locations to join the fight against health inequities and resist and subvert white supremacy and racism in healthcare.

References

Abrams, L. S., & Detlaff, A. (2020, June 18). *An open letter to NASW and allied organizations on social work's relationship with law enforcement*. https://alandettlaff.medium.com/an-open-letter-to-nasw-and-allied-organizations-on-social-works-relationship-with-law-enforcement-1a1926c71b28

Abramovitz, M. (1998). Social work and social reform: an arena of struggle. Social Work, 43(6), 512–526. https://doi.org/10.1093/sw/43.6.512.

Acheson, K. (2006). Black shepherd, white sheep: A phenomenological study of a southern church. *Race, Gender & Class*, 170-190.

Adelman, L. (2011). Guest Forward: An aroused opinion. *The Journal of Health Promotion and Maintenance, January/March,* 1-8.

Adjei, P. (2013). When Blackness shows up uninvited: Examining the murder of Trayvon Martin through Fanonian racial interpellation. In G. J. Sefa Dei & M. Lordan (Eds.), *Contemporary issues in the sociology of race and ethnicity: A critical reader* (1st ed., pp. 25–41). Peter Lang.

Adjei, P.B. (2018). The (em)bodiment of blackness in a visceral anti-black racism and ableism context, *Race, Ethnicity, and Education, 21*(3), 275-287. https://doi: 10.1080/13613324.2016.1248821

Adjei, P. B., & Minka, E. (2018). Black parents ask for a second look: Parenting under "White" Child Protection rules in Canada. Children and Youth Services Review, 94, 511–524. https://doi.org/10.1016/j.childyouth.2018.08.030

Ahmed, S. (2004). Declarations of whiteness: The non-performativity of anti-racism.

Borderlands, 3(2), 1-15.

Ahmed, S. (2007). A phenomenology of whiteness. *Feminist Theory, 8*(2), 149-168.

Ahmed, S. (2016). How Not to Do Things with Words. *Wagadu: A Journal of Transnational Women's and Gender Studies, 16*, 1-10.

Al-Saji, A. (2014). A phenomenology of hesitation: Interrupting racializing habits of seeing. In E. S. Lee (Ed.). *Living alterities: Phenomenology, embodiment, and race* (pp. 133-172). SUNY Press.

Alcoff, L. (1991). The problem of speaking for others. *Cultural Critique, Winter*(20), 5-32.

Alegría, M., Fukuda, M., Lapatin Markle, S., & NeMoyer, A. (2019). Mentoring future researchers: Advice and considerations. *American Journal of Orthopsychiatry, 89(*3), 329–336. https://doi.org/10.1037/ort0000416

Allen, D. (2006). Whiteness and difference in nursing. *Nursing Philosophy, 7*(2), 65-78.

American Association of Colleges of Nursing. Enhancing diversity in the workforce. https://www.aacnnursing.org/News-Information/Fact-Sheets/Enhancing-Diversity

Allen, Q. & White-Smith, K. (2015). "Just as bad as prison:" The challenge of dismantling the school-to-prison pipeline through teacher and community education. *Equity and Excellence, 47*(4), 445–460.

Alexander, M. (2012). *The New Jim Crow: Mass Incarceration in the Age of Colorblindness.* The New Press.

Alvaro, Reyes. (2012). "On Fanon's Manichean Delirium." *The Black scholar* 42, 3-4.

American Academy of Social Work & Social Welfare (AASWSW). (2019). Grand Challenges for Social Work. https://grandchallengesforsocialwork.org.

American Association of Medical Colleges (AAMC). (n.d.). Percentage of all active physicians

by race/ethnicity, 2018. https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

American Medical Association (AMA). (n.d.). Mission. https://www.ama-assn.org/about

American Nurses Association (ANA). (n.d.). Code of Ethics for Nurses. https://www.nursingworld.org/coe-view-only

American College of Healthcare Executives (ACHE). (2020). Increasing and Sustaining Racial Diversity in Healthcare Leadership. https://www.ache.org/about-ache/our-story/our-commitments/policy-statements/increasing-and-sustaining-racial-diversity-in-healthcare-management

Annamma, S., Ferri, B. & Connor, D. (2018). Disability Critical Race Theory: Exploring the intersectional lineage, emergence, and potential futures of DisCrit in education. *Review of Research in Education 42(1)*, 46–71. https://doi.org/10.3102/0091732X18759041

Anderson, C. (2016). *White rage: The unspoken truth of our racial divide*. Bloomsbury.

Anderson, K.O., Green, C.R., & Payne, R. (2009). Racial and ethnic disparities in pain: Causes and consequences of unequal care. *Journal of Pain, 10(*12), 1187–1204.

Anderson-Nathe, B. (2008). Investigating not-knowing: research methodology. *Child & Youth Services, 30*(1), 27-42. http://dx.doi.org/10.1080/01459350802156557

Applebaum, B. (2006). Race Ignore-Ance, colortalk, and white complicity: White Is...white Isn't. *Educational Theory, 56*(3), 345–362. https://doi-org.qe2a-proxy.mun.ca/10.1111/j.1741-5446.2006.00230.x

Applebaum, B. (2010). *Being White, being good: White complicity, white moral responsibility, and social justice pedagogy*. Lexington Books.

Applebaum, B. (2015). Flipping the script...and still a problem: Staying in the

anxiety of being a problem. In Yancy, G. (Ed.), *White Self-Criticality beyond anti-racism: How does it feel to be a white problem?* Lexington Books.

Argueza, B. R., Saenz, S. R., & McBride, D. (2021). From Diversity and Inclusion to Antiracism in Medical Training Institutions. *Academic Medicine: Journal of the Association of American Medical Colleges*, *96*(6), 798–801. https://doi.org/10.1097/ACM.0000000000004017

Arsenault, R. (2007). *Freedom riders: 1961 and the struggle for racial Justice*. Oxford University Press.

Andrasfay, T., & Goldman, N. (2021). Reductions in US life expectancy during the COVID-19 pandemic by race and ethnicity: Is 2021 a repetition of 2020? M*edRxIV: The Preprint Server for Health Sciences*. https://doi.org/10.1101/2021.10.17.21265117

Atterbury, A. (2023). DeSantis defends banning African American studies course as Black leaders call for action. https://www.politico.com/news/2023/01/23/desantis-banning-african-american-studies-00079027

Azhar, S. & McCutcheon, K. (2021). How racism against BIPOC women faculty operates in social work academia. Advances in Social Work, 21(2/3), 396-420.

Badwall, H. (2014). Colonial encounters: Racialized social workers negotiating professional scripts of whiteness. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 3*, 1-23.

Bailey, A. (1998). Locating traitorous identities: Toward a view of privilege-cognizant white character. *Faculty Publications - Philosophy.* https://ir.library.illinoisstate.edu/fpphil/5

Bailey, M. (2019). Open letter to editors of journal of the national medical association from the black feminist health science studies collective. *Journal of the National Medical*

Association, 111(5), 573-575. http://dx.doi.org/10.1016/j.jnma.2019.04.003

Bailey, Z., Feldman, J., & Basset, M. (2021). How structural racism works — Racist policies as a root cause of U.S. racial health inequities. *New England Journal of Medicine, 384*(8). https://www.nejm.org/doi/pdf/10.1056/NEJMms2025396?articleTools=true

Baker, R. Blanchard, J., Boulware, L.E., Braddock, C., Bristow, L. Corbie-Smith, G., Crawley, L., Hoover, E., Jacobs, E.., LaVeist, T., Maxey, R., Mills, C., Moseley, K., Savitt, T. Washington, H., & Williams, D. (2008). African American history and organized medicine: Acknowledging our painful legacy. *American Medical Association* (*AMA*). https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ama-history/african-american-physicians1.pdf

Baker, R. B., Washington, H. A., Olakanmi, O., Savitt, T. L., Jacobs, E., Hoover, E., & Wynia, M. (2009). Creating a segregated medical profession: African American physicians and organized medicine, 1846-1910. *Journal of the National Medical Association, 101*(6), 501-512. http://libproxy.lib.unc.edu/login?url=https://www.proquest.com/scholarly-journals/creating-segregated-medical-profession-african/docview/214032998/se-2?accountid=14244

Baldwin, J. (1962, November). Letter from a region in my mind. *The New Yorker*. https://www.newyorker.com/magazine/1962/11/17/letter-from-a-region-in-my-mind

Baldwin, J. (1984/2012). *Notes of a native son*. Boston, MA: Beacon Press.

Baldwin, J. (1985). *The price of a ticket*. St. Martin's Press.

Banaji, M.R., Fiske, S.T. & Massey, D.S. (2021). Systemic racism: Individuals and interactions, institutions and society. *Cognitive Research 6*, 82. https://doi.org/10.1186/s41235-021-00349-3

Banks, L., Hopps, G. & Briggs, H. (2018). Cracks in the ceiling? Historical and contemporary trends of African American deans of Schools of Social Work. *Research on Social Work Practice. 28*(3), 288-299.

Banerjee, M. (2005). Applying Rawlsian social justice to welfare reform: An unexpected finding for social work. *Journal of Sociology and Social Work, 32*(2), 35–57.

Banerjee, M. (2011). Social Work scholars' representation of Rawls: A critique. Journal of Social Work Education, 47(2), 189-211.

Bartlett, H.M. (1934). Medical Social Work: A Study of Current Aims and Methods in Medical Social Case Work. *American Association of Medical Social Workers.*

Barthold, D. (2023). Inflating the Monster: The systematic co-optation, commodification, and colonization of Critical Race Theory in the news media. A Critical Analysis of CRT news coverage. Department of Communication and Media at the University of Michigan.

Beard, K. V., & Julion, W. A. (2016). Does race still matter in nursing? The narratives of African American nursing faculty members. *Nursing Outlook, 64*(6), 583–596. https://doi-org.libproxy.lib.unc.edu/10.1016/j.outlook.2016.06.005

Beck, E. (2019). Naming white supremacy in the social work curriculum. *Affilia: Journal of Women and Social Work, 34*(3), 393-398.

Bell, B. (2020). White dominance in nursing education: A target for anti-racist efforts. *Nursing Inquiry,* 28, 1, https://doi.10.1111/nin.12379, ,

Bell, D. A. (1980). Brown v. Board of education and the Interest-Convergence dilemma. *Harvard Law Review*, *93*(3), 533. https://doi.org/10.2307/1340546

Bell, D. (1987). And we are not saved: The elusive quest for racial justice. Basic Books.

Bell, D. (1992/2018). Faces at the bottom of the well: The permanence of racism. Hachette.

Bell, D. (1995). Who's afraid of Critical Race Theory? *University of Illinois Law Review,* 893-910.

Bell, D. (2000). Wanted: A White Leader Able to Free Whites of Racism. *U.C. Davis Law Review, 33*(3).

Bernard, W.T.& Smith, H. (2018). Injustice, justice, and Africentric Practice in Canada. *Canadian Social Work Review, 35*(1), 149–157. https://id.erudit.org/iderudit/1051108ar

Berry, M.E. (1989). Confrontation at the national conference on social welfare. *Social Service Review.* 63 (4). 630-656.

Bhuyan, R., Bejan, R., & Jeyapal, D. (2017). Social workers' perspectives on social justice in social work education: When mainstreaming social justice masks structural inequalities. *Social Work Education: The International Journal, 36*(4), 373-390.

Bilge, S. (2013). Intersectionality undone: Saving intersectionality from feminist intersectionality studies. DuBois Review: *Social Science Research on Race*, *10* (2), 405-424.

Billingsley, A. (1968) Black families in White America. Prentice-Hall.

Billingsley, A. (1973) Black family structure: Myths and realities. In Hill, R. (1997) *The strength of African American families: Twenty-five years later* (2nd ed) R and B Publishers.

Bird, C. M., Webb, E. K., Schramm, A. T., Torres, L., Larson, C., & deRoon-Cassini, T. A. (2021). Racial Discrimination is Associated with Acute Posttraumatic Stress Symptoms and Predicts Future Posttraumatic Stress Disorder Symptom Severity in Trauma-Exposed Black Adults in the United States. *Journal of Traumatic Stress, 34*(5), 995–1004. https://doi.org/10.1002/jts.22670

Birzer, M. L., & Smith-Mahdi, J. (2006). Does race matter? The phenomenology of discrimination experienced among African Americans. *Journal of African American*

Studies, *10*(2), 22-37.

Bobo, L. (2013). Introduction. In. Dubois, W.E.B. *The Philadelphia Negro: A sociological study.* Gates, H.L. (Ed.). Oxford University Press.

Boddy, C. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal, 19*(4), 426-432.

Bonilla-Silva, E. (2018). *Racism without racist* (5th ed.). Rowman & Littlefield.

Bonner, A., & Tolhurst, G. (2002). Insider/outsider perspectives of participant observation. *Nurse Researcher, 9*(4), 7-19.

Booker, S. Q., Herr, K. A., & Wilson Garvan, C. (2020). Racial Differences in Pain Management for Patients Receiving Hospice Care. *Oncology Nursing Forum*, *47*(2), 228–240. https://doi.org/10.1188/20.ONF.228-240

Bowie, S. L., Nashwan, A. J., Thomas, V., Davis-Buckley, R. J., & Johnson, R. L. (2018). An Assessment of social work education efforts to recruit and retain MSW students of color. *Journal of Social Work Education, 54*(2), 270-286. https://doi.org/10.1080/10437797.2017.1404531

Bowleg, L., Del Río-González, A. M., Holt, S. L., Pérez, C., Massie, J. S., Mandell, J. E., & A Boone, C. (2017). Intersectional Epistemologies of Ignorance: How Behavioral and Social Science Research Shapes What We Know, Think We Know, and Don't Know About U.S. Black Men's Sexualities. *Journal of Sex Research*, *54*(4-5), 577–603. https://doi.org/10.1080/00224499.2017.1295300

Bowles, D. & Hopps, J. (2014). The profession's role in meeting its mission to serve vulnerable populations. *Advances in Social Work*, *15*(1), 1–20. https://doi.org/10.18060/16677

Bracht, N. (1999) Health promotion at the community level: New advances. Sage Publications

Bradbury-Jones C., Sambrook S. & Irvine F. (2009). The phenomenological focus group: an oxymoron? *Journal of Advanced Nursing* 65(3), 663–671. https://doi: 10.1111/j.1365-2648.2008.04922.x

Brandt, A. M. 1978. Racism and research: The case of the Tuskegee Syphilis study. *The Hastings Center Report, 8*(6), 21-29. http://nrs.harvard.edu/urn-3:HUL.InstRepos:3372911

Braveman, P. A., Kumanyika, S., Fielding, J., Laveist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: the issue is justice. American journal of public health, 101 Suppl 1(Suppl 1), S149–S155. https://doi.org/10.2105/AJPH.2010.300062

Braveman, P. A. (2014). What are health disparities and health equity? We need to be clear. *Public health reports, 129*(Suppl 2), 5–8. https://doi.org/10.1177/00333549141291S203

Brice, T. & McLane-Davison, D. (2020). The Strength of Black Families: The Elusive Ties of Perspective and Praxis in Social Work Education. *KU Scholar Works*. https://kuscholarworks.ku.edu/handle/1808/30253

Briggs, H. E., Holosko, M. J., Banks, L., Huggins-Hoyt, K. Y. & Parker, J. (2018). How are African Americans currently represented in various social work venues? *Research on Social Work Practice*, *28*(3), 275-287.

Brinkmann, S., Jacobsen, M. & Kristiansen, S. (2014). Historical overview of qualitative research in the social sciences. In P. Leavy (Ed.), *The Oxford Handbook of Qualitative Research*. Oxford Press.

Brown, D. (2020, June 3). 'It was a modern-day lynching': Violent deaths reflect a brutal American legacy. *National Geographic*. https://www.nationalgeographic.com/history/article/history-of-lynching-violent-deaths-

reflect-brutal-american-legacy

Brown, J. (1854). Slave life in Georgia: A narrative of the life, sufferings, and escape of John Brown, a fugitive slave, now in England. Chamerovzow, L.A. (Ed.). Electronic Edition. https://docsouth.unc.edu/neh/jbrown/jbrown.html

Brown, S. L., Johnson, Z., & Miller, S. E. (2019). Racial microaggressions and black social work students: a call to social work educators for proactive models informed by social justice. *Social Work Education, 38*(5), 618–630.

Brown-Speights, J. S., Goldfarb, S. S., Wells, B. A., Beitsch, L., Levine, R. S., & Rust, G. (2017). State-Level progress in reducing the Black-White infant mortality gap, United States, 1999-2013. *American Journal of Public Health*, *107*(5), 775–782. https://doi.org/10.2105/AJPH.2017.303689

Bryant, D. & Kolivoski, K. (2021). The stories we tell: Examining the persistence and impacts of normative-whiteness and white supremacy within social work education. *Advances in Social Work, 21*(2), 481-499. https://doi.org/10.18060/24158.

Buggs, S., Sims, J. & Kramer, R. (2020). Rejecting white distraction: a critique of the white logic and white methods in academic publishing. *Ethnic and Racial Studies*, *43*(8), 1384-1392. https://DOI:10.1080/01419870.2020.1718728

Bussey, S. (2021). Finding a path to anti- racism: Pivotal childhood experiences of White helping professionals. *Qualitative Social Work, 20*(4), 1025–1042.

Bussey, S. (2020). Imperialism through Virtuous Helping: Baldwin's Innocence and Implications for Clinical Social Work Practice. *Journal of Progressive Human Services, 31*(3), 192- 209. https://doi.org/10.1080/10428232.2019.1617016

Cabot, R. C. (1909). *Social service and the art of healing*, New York, NY: Moffat, Yard, and

Company.

Cabot, R. C. (1919). Social work: Essays on the meeting-ground of doctor and social worker. Houghton Mifflin.

Cabrera, N. (2017). White immunity: working through some of the pedagogical pitfalls of “privilege.” Journal Committed to Social Change on Race and Ethnicity, 3 (1), 78-90.

Calero, S., Kopić, K., Lee, A., Nuevelle, T., Spanjaard, M., & Williams, T. (2017). On the problematization and criminalization of children and young adults with non-apparent disabilities. *The Ruderman White Paper*. https://rudermanfoundation.org/white_papers/criminalization-of-children-with-non-apparent-disabilities/

Cannon, I. M. (1917). *Social work in hospitals*. Russell Sage Foundation.

Campbell, K. (2021). The diversity efforts disparity in academic medicine. *International Journal of Environmental Research in Public Health, 18*(9), 4529.

Campbell, K., Corral, I., Linares, J. & Tumin, D. (2020). Projected estimates of African American medical graduates of closed historically Black medical schools. *JAMA Network Open, 3*(8). https://doi.10. 1001/jamanetworkopen.2020.15220

Carlton-LaNey, I. (1999). African American social work pioneers' response to need. Social Work, 44(4), 311– 321. https://doi.org/10.1093/sw/44.4.311.

Carlton-La Ney, I. (2001). *African American leadership in social work history: An empowerment tradition*. NASW Press.

Carlton-LaNey, I., & Burwell, N. Y. (2014). *African American community practice models: Historical and contemporary responses*. Routledge.

Carroll, W. K. (Ed.). (2004). *Critical strategies for social research*. Canadian Scholars’ Press.

Carten, A. (2016, August 21). *How racism has shaped welfare policy in America since 1935*.

The Conversation. https://theconversation.com/how-racism-has-shaped=welfare-policy-in -america-since-1935-63574

Case, K. (2012). Discovering the privilege of whiteness: White women's reflections on anti-racist identity and ally behavior. *Journal of Social Issues, 68*(1), 78-96.

Centers for Disease Control (CDC). (n.d.). Social determinants of health: Know what affects health. https://www.cdc.gov/socialdeterminants/index.htm

Centers for Disease Control (CDC). (2021). Pregnancy mortality surveillance system. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_ AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductiveh ealth%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillan ce-system.htm.

Chambers, B. D., Baer, R. J., McLemore, M. R., & Jelliffe-Pawlowski, L. L. (2019). Using index of concentration at the extremes as indicators of structural racism to evaluate the association with preterm birth and infant mortality—2011-2012, California. *Journal of Urban Health, 96*, 159–170.

Chang, M. J., Eagan, M. K., Lin, M. H., & Hurtado, S. (2016). Considering the impact of racial stigmas and science identity: Persistence among biomedical and behavioral science aspirants. *The Journal of Higher Education*, *82*(5), 564–596. https://doi.org/10.1080/00221546.2011.11777218

Chapman, C. & Withers, A.J. (2019). A violent history of Benevolence: Interlocking oppression in the moral economies of social working. University of Toronto Press.

Chen, J. T., & Krieger, N. (2020). Revealing the unequal burden of COVID-19 by income, race/ethnicity, and household crowding: US county versus zip code analyses. Journal

of Public Health Management and Practice, 27, S43. https://doi.org/10.1097/PHH.0000000000001263.

Churchwell, K., Elkind, M.S., Benjamin, R.M., Carson, A.P., Chang, E.K., Lawrence, W., Mills, A., Odom, T.M., Rodriguez, C.J., Rodriguez, F., Sanchez, E., Sharrief, A.Z., Sims, M., &.

Cintron, A., & Morrison, R.S. (2006). Pain and ethnicity in the United States: A systematic review. *Journal of Palliative Medicine, 9*(6), 1454–1473

Cleeland, C.S., Gonin, R., Baez, L., Loehrer, P., & Pandya, K.J. (1997). Pain and treatment of pain in minority patients with cancer. The Eastern Cooperative Oncology Group Minority Outpatient Pain Study. *Annual Internal Medicine, 127*(9), 813–816.

Collins, P.H. (2015). Intersectionality's Definitional Dilemmas. *Annual Review of Sociology, 41*(1), 1-20

Collins, P.H. (1986). Learning from the outsider within: The sociological significance of Black feminist thought. *Social Problems, 33*(6). S14-S32. https://www.jstor.org/stable/800672

Combahee River Collective. (2014). A Black Feminist Statement. *Women's Studies Quarterly*, *42*(3/4), 271–280. http://www.jstor.org/stable/24365010.

Constance-Huggins, M. (2019). Critical Race Theory and social work. In Webb, S. (Ed.), *The Routledge handbook of critical social work.* Routledge.

Cooper, L. & Roter, D. (2003). Patient-Provider Communication: The Effect of Race and Ethnicity on Process and Outcomes on Healthcare. In Smedley, B.D., Stith, A.Y., & Nelson, A.R. (Ed.). (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* National Academies Press.

Corley, N. A. & Young, S. M. (2018). Is Social Work Still Racist? A Content Analysis of

Recent Literature. *Social Work (New York), 63*(4), 317-326.

Council on Social Work Education (CSWE). (2021). An update from the antiracism task force. https://www.cswe.org/News?General-News-Archives/An-Update-From-the-Anti-Racism-Task-Force.

Cox, L., Tice, C. & Long, D. (2019). *Introduction to Social Work: An Advocacy-Based Profession* (2nd ed.). Sage Publications.

Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*,1241–1299.

Crenshaw, K., Carbado, D., & Flanders, L. (2021a, August 31). What is Critical Race Theory and Why is it Under Attack? The New Press. https://www.youtube.com/watch?v=0yHuCjQ5pUA

Crenshaw, K., Cook, A., Hosang, D., Ladson-Billings, G., Peller, G., & Williams, R. (2021b, September 2). Looking Back to Move Forward: The Insurgent Origins of Critical Race. Intersectionality Matters! Podcast. https://soundcloud.com/intersectionality-matters/39-looking-back-to-move-forward-the-insurgent-origins-of-critical-race-theory

Crenshaw, K., Gotanda, N., Peller, G., & Thomas, K. (Eds.). (1995). *Critical Race Theory: The key writings that formed the movement.* The New Press.

Creswell, J. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Sage Publications.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches.* Sage Publications.

Crist, J. & Tanner, C. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research, 52*(3).

Cronin, C. & Lowes, J. (2015). Brief encounters with qualitative methods in health research: Phenomenology and interpretative phenomenological analysis. *Pre-publication Document.* https://www.academia.edu/10756759/Brief_Encounters_with_Qualitative_Methods_in_Health_Research_Phenomenology_and_Interpretative_Phenomenological_Analysis?email_work_card=view-paper

Cypress, B. (2017). Exploring the philosophical, paradigmatic, conceptual-theoretical underpinnings of qualitative research: A focus on phenomenological study in intensive care unit. *Dimensions of Critical Care Nursing*, *36*(3), 208-216.

Cunningham, A. (2020, August 25). What we can learn from how a doctor's race can affect Black newborns' survival. *Science News. https://www.sciencenews.org/article/black-newborn-baby-survival-doctor-race-mortality-rate-disparity*

de Witt, L. & Ploeg, J. (2005). Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing 55*(2), 215–229. https//: doi: 10.1111/j.1365-2648.2006.03898.x

Deepak, A. (2019). Postcolonial feminist social work. In Webb, S. (Ed.), *The Routledge handbook of critical social work.* Routledge.

De La Torre, M. (2018). Academic Racism: The Repression of Marginalized Voices in Academia. https://activisthistory.com/2018/08/29/academic-racism-the-repression-of-marginalized-voices-in-academia/

Delgado, R. (1989). Storytelling for Oppositionists and Others: A Plea for Narrative. *Michigan Law Review, 87*(2411) https://repository.law.umich.edu/mlr/vol87/iss8/10

Delgado, R. & Stefancic, J. (2001/2017). Critical race theory. An introduction. New York

University Press.

Delgado, R. & Stefancic, J. (2007). Critical Race Theory and Criminal Justice. *Humanity & Society, 31*(May/August), 133-145.

Denzin, N. & Lincoln, Y. (Eds). (2018). The Sage handbook of qualitative research (5th ed.). Sage Publications.

deShazo, R. (2018). *The racial divide in American medicine: Black physicians and the struggle for justice in health care*. University Press of Mississippi.

Dettlaff, A. (2020, July). *A call to act against racism and white supremacy now*. The New Social Worker. https://www.socialworker.com/feature-articles/practice/call-to-social-workers-act-against-racism-white-supremacy/

Dettlaff, A., Weber, K., Pendleton, M. Boyd, R., Bettencourt, B. & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upEND movement to abolish the child welfare system. *Journal of Public Child Welfare, 14*(5), 500-517. https://DOI:10.1080/15548732.2020.1814542

Disprose, R. & Reynolds, J. (Eds.) (2014). *Merleau-Ponty: Key Concepts.* Routledge.

Dittmer, J. 2009). The good doctors: The medical committee for human rights and the struggle for social justice in health care. Bloomsbury Press.

Dominelli, L. (1997). *Anti-racist social work: A challenge for white practitioners and educators*. British Association of Social Workers (BASW) Practical Social Work.

Donner, J.K. & Ladon-Billings, G. (2018). Critical race theory and the post racial imaginary. In Denzin, N. K., & Lincoln, Y. S. (Eds.), *The Sage handbook of qualitative research*. Sage.

Doyle, D. (2009a). 'A Fine New Child': The Lafargue Mental Hygiene Clinic and Harlem's African American Communities, 1946–1958. *Journal of the History of Medicine, 64*(2),

173–212. https://doi:10.1093/jhmas/jrn064

Doyle, D. (2009b). 'Where the Need Is Greatest': Social Psychiatry and Race-Blind Universalism in Harlem's Lafargue Clinic, 1946–1958. *Bulletin of the History of Medicine, 83*(4), 746–774. https://doi:10.1353/bhm.0.0276

Dreyfus, H. & Wrathall, M. (2005). Martin Heidegger: An Introduction to His Thought, Work, and Life. In Dreyfus, H. & Wrathall, M. (Eds.), *A Companion to Heidegger.* Blackwell Publishing Ltd

Drover, G. (2019). Social Work. In *The Canadian Encyclopedia*. Retrieved from https://www.thecanadianencyclopedia.ca/en/article/social-work

Du Bois, W.E.B. (1899/2013). *The Philadelphia Negro: A sociological study.* Gates, H.L. (Ed.). Oxford University Press.

DuBois, W.E.B. (1903/1986). The Souls of Black Folk. In *DuBois Writings.* Literary Classics of the United States, Inc. 357-548.

Du Bois, W.E.B. (1906/2003). The health and physique of the Negro: Report of a social study made under the direction of Atlanta University; Together with the proceedings of the Eleventh Conference for the Study of the Negro Problems, May the 29th, 1906. *American Journal of Public Health, 93(2).* https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.2.272

Du Bois, W.E.B. (1920). *Darkwater: Voices from within the veil.* Harcourt, Brace and Howe. Retrieved from https://web.archive.org/web/20110116164449/http://etext.lib.virginia.edu/etcbin/toccer-new2?id=DubDark.xml&images=images/modeng&data=/texts/english/modeng/parsed&tag=public&part=all.

Du Bois, W.E.B. (1935). *Black Reconstruction in America 1860-1880*. The Free Press.

Du Bois, W.E.B. (2007). *John Brown.* Gates, H.L. (Ed.). *In The Oxford W.E.B Du Bois*. The Oxford University Press.

Dumbrill, G. & Yee, J. (2019). *Anti-oppressive social work: Ways of knowing, talking, and doing*. Oxford University Press.

Dyer, R. (2005). The Matter of whiteness. In P. Rothenberg (Ed.), *White privilege: Essential readings on the other side of racism,* pp. 9-12, *2nd ed*. Worth Publishers.

Dyson, Y. & Brice, T. S. (2016) Embracing the village and tribe: Critical thinking for social workers from an African-Centered Approach. *Journal of Social Work Education, 52(*1), 108-117. https://doi.org/10.1080/10437797.2016.1112648

Echavarri, F. (2021, October). Scientists in Africa are taking it upon themselves to create a COVID vaccine for the world's poor. *Mother Jones.* https://www.motherjones.com/politics/2021/10/scientists-in-africa-are-taking-it-upon-themselves-to-create-a-covid-vaccine-for-the-worlds-poor/

Effland, K. J., Hays, K., Ortiz, F. M. & Blanco, B. A. (2020). Incorporating an Equity Agenda into Health Professions Education and Training to Build a More Representative Workforce. *Journal of Midwifery & Women's Health*, *65*(1).

Egede, L. & Walker, R. (2020). Structural Racism, Social Risk Factors, and Covid-19 — A Dangerous Convergence for Black Americans. New England Journal of Medicine, 383(e77). https://www.nejm.org/doi/full/10.1056/NEJMp2023616

Elkassem, S. & Murray-Lichtman (2022). Mapping an Integrative Critical Race and Anti-Colonial Theoretical Framework in Social Work Practice. Advances in Social Work, 22(2), 628-646. https://doi: 10.18060/24952.

https://journals.iupui.edu/index.php/advancesinsocialwork/issue/current

Emejulu, A. & Bassel, L. (2020). The politics of exhaustion. *City, 24(*1-2), 400-406. https://doi: 10.1080/13604813.2020.1739439

English Standard Version Bible. (n.d.). ESV Online. https://esv.literalword.com/.

Este, D., Sato, C., & McKenna, D. (2017). The coloured women's club of Montreal, 1902-1940: African-Canadian women confronting anti-Black racism. *Canadian Social Work Review, 34*(1), 81-99.

Fanon, F. (1952/2008). *Black skin, white masks.* Grove Press.

Fanon, F. (1963). The wretched of the earth. Grove Press.

Feagin, J. (2013). *The white racial frame: Centuries of racial framing and counter-framing* (2nd ed.). Taylor & Francis.

Feagin, J. (2004). Social justice and sociology: Agendas for the twenty-first century. In W. K. Carroll (Ed.), *Critical strategies for social research*. Canadian Scholars' Press.

Feagin, J., & Bennefield, Z. (2014). Systemic racism & U.S. health care. Social Science & Medicine, 103, 7-14. https://doi.org/10.1016/j.socscimed.2013.09.006

Feagin, J., & Ducey, K. (2019). *Racist America: Roots, Currents Realities, and Future Reparations* (4th ed.). Routledge.

Feagin, J., & O'Brien, E. (2003). White men on race: Power, privilege, and the shaping of cultural consciousness. Beacon Press.

Fellows, M. L., & Razack, S. (1998). The race to innocence: Confronting hierarchical relations amongst women. *Journal of Gender, Race, and Justice*, *1*(2), 335-352. https://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1278&context=faculty_articles

Fett, S. (2002). *Working Cures: Healing, health, and power on southern slave plantations.* University of North Carolina Press.

Fingerhut, A. W., & Hardy, E. R. (2020). Applying a model of volunteerism to better understand the experiences of White ally activists. *Group Processes & Intergroup Relations*, *23*(3), 344–360. https://doi-org.qe2a-proxy.mun.ca/10.1177/1368430219837345

Finkelman, P. (2011). A look back at John Brown. National Archives, Prologue Magazine, 43(1). https://archives.gov/publications/prologue/2011/spring/brown.html

Finn, J. (2021). *Just Practice: A social justice approach to social work.* (4th ed.). Oxford University Press.

FitzGerald, C., Martin, A., Berner, D., & Hurst, S. (2019). Interventions designed to reduce implicit prejudices and implicit stereotypes in real world contexts: a systematic review. *BMC Psychology, 7*(1), 29. https://doi: 10.1186/s40359-019-0299-7.

Flexner, A. (1910). *Medical Education in the United Sates and Canada.* Science and Health Publications. http://archive.carnegiefoundation.org/publications/pdfs/elibrary/Carnegie_Flexner_Report.pdf

Flexner, A. (1915/2001). Is social work a profession? *Research on Social Work Practice, 11*(2), 152-165.

Fontenot, K., Semega, J., & Kollar, M. (2018). Income and poverty in the United States: 2017. *Current Population Reports*, No. P60-263. US Census Bureau.

Fortier, C. & Wong, H. S. (2019). The settler colonialism of social work and the social work of settler colonialism. *Settler Colonial Studies, 9*(4), 437-456.

Foucault, M. (2010). *The archaeology of knowledge and the discourse on language.*

(A.M.S., Smith, Trans.). Vintage Books. (Original work published

Frakt, A. (2020, July). Bad Medicine: The harm that comes from racism. *The New York Times*. https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html

Frankenberg, R. (1993). *White women, race matters: The social construction of whiteness*. University of Minnesota Press.

Frey, W., Mann, N., Boling, A., Jordan, P. Lowe, K. & Witte, S. (2021). Uprooting (our) whiteness. Advances in Social Work, 21(2/3), 954-977.

Friel, S. & Marmot, M. (2011). Action on the social determinants of health and health inequities goes global. *Annual Review of Public Health, 32,* 225-236. https://doi: 10.1146/annurev-publhealth-031210-101220

Gawronski, B. (2019). Six Lessons for a Cogent Science of Implicit Bias and Its Criticism. *Perspective Psychology Science*, *14(*4), 574-595. http://doi: 10.1177/1745691619826015.

Gilbert, S. (2021, October). January 6 wasn't a riot. It was war. *The Atlantic.* https://www.theatlantic.com/culture/archive/2021/10/hbo-four-hours-at-the-capitol-january-6-documentary-review/620464/

Giwa, S. (2018). Coping with racism and racial trauma: An interpretive phenomenological analysis of how gay men from the African diaspora experience and negotiate racist encounters. In Riggs, D.W. (Ed.), *The psychic life of racism in gay men's communities.* Lexington Books. https://www.academia.edu/35578380/Coping_with_Racism_and_Racial_Trauma_An_Interpretative_Phenomenological_Analysis_of_How_Gay_Men_from_the_African_Diaspora_Experience_and_Negotiate_Racist_Encounters

Gosine, K., & Pon, G. (2011). On the front lines: The voices and experiences of racialized child welfare worker in Toronto, Canada. *Journal of Progressive Human Services*, *22*(2), 135-159. https://doi.org/10.1080/10428232.2011.599280

Goldstein, H. (1990). The knowledge base of social work practice: Theory, wisdom, analogue, or art? *The Journal of Contemporary Human Services, January*, 32-43.

Goyal, M.K., Kuppermann, N., Cleary, S.D., Teach, S.J., & Chamberlain, J.M. (2015). Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatrics*, *169*(11), 996–1002.

Goyal, M., Johnson, T., Chamberlain, J., Cook, L., Webb, M. Drendel, A., Alessandrini, E., Bajaj, L., Lorch, S., Grundmeier, R., & Alpern, E. (2020, May). Pediatric Emergency Care Applied Research Network (PECARN). *Pediatrics, 145*(5). https://DOI: 10.1542/peds.2019-3370

Graham, L., Brown-Jeffy, S., Aronson, R. & Stephens, C. (2011). Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health*, *21*(1), 81–93.

Green, T. & Hagiwara, N. (2020). The problem with implicit bias training. Scientific America. https://www.scientificamerican.com/article/the-problem-with-implicit-bias-training/

Greenwood, B., Hardeman, R., Huang, L., & Sojourner, A. (2020). Physician-patient racial concordance and disparities in birthing mortality for newborns.

Gregory, J. (2021). Toward a historically accountable critical whiteness curriculum for social work. *Advances in Social Work, 21*(2/3), 616-635. http://journals.iupui.edu/index.php/advancesinsocialwork/article/view/24115

Gregory, J. (2020). Social work as a product and project of Whiteness, 1607-1900. Journal of

Progressive Human Services, 32(1), 1-20.

Griffin, J.H. (1960). Black like me. Signet.

Groenewald, T. (2004). A phenomenological research design illustrated. International Journal of Qualitative Methods, 3(1).

Hagerman, M. (2018). *White Kids: Growing up with privilege in a racially divided America*. The New York University Press.

Hall, W. (1954). Janie Porter Barrett: Her life and contributions to social welfare in Virginia. Thesis dissertation. MS Howard University.

Halsell, G. (1999). *Soul Sister*. Crossroads International Publishing.

Hamel, Liz, Lopes, L., Munana, C., Artiga, S., & Brodie, M. (2020). Race, Health, and COVID-19: The views and experiences of Black Americans. Key Findings from the KFF/Undefeated Survey on Race and Health. https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf

Hardeman, R. R., Medina, E. M., & Kozhimannil, K. B. (2016a). Dismantling structural racism, supporting black lives, and achieving health equity: The role of health professionals. *New England Journal of Medicine*, *375*(22), 2113–2115. https://doi.org/10.1056/NEJMp1609535.Dismantling

Hardeman, R. R., Medina, E. M., & Kozhimannil, K.B. (2016b). Structural racism and supporting black lives—the role of health professionals. *New England Journal of Medicine, 375*(22), 2113-2115.

Hardeman, R. R., Murphy, K. A., Karbeah, J., & Kozhimannil, K. B. (2018). Naming Institutionalized Racism in the Public Health Literature: A Systematic Literature Review.

Public Health Reports, 133(3), 240–249. https://doi.org/10.1177/0033354918760574

Hardeman, R. R., Medina, E. M., & Boyd, R. W. (2020). Stolen breaths. *New England Journal of Medicine*, *10*, 1–2. https://doi.org/10.1056/ NEJMp2009027

Hargrove, T. (2021). Structural Racism and Inequalities in Health. APA Footnotes, 49(2), 3-5. https://footnotes.asanet.org

Harnett, N., Dumorray, N., Lebois. L., & Ressler, K. (2023). Racial Disparities in Adversity During Childhood and the False Appearance of Race-Related Differences in Brain Structure. American Journal of Psychiatry, 180(2). https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.21090961

Harris, C.I. (1993). Whiteness as property. *Harvard Law Review*, *106*(8), 1707–1791.

Harty, J. (2021). Black contributions to social welfare & social work history: A legacy of Black self-help, resistance and liberation. Equity & Inclusion Speaker Series. http://www.bu.edu/ssw/files/2021/02/Harty-BlackSWSW-Boston-20210225.pdf

Hassouneh, D. (2006). Anti-racist Pedagogy: Challenges faced by faculty of color in predominantly white schools of nursing. *Journal of Nursing Education, 45*(7), 255-262

Hassouneh, D., Akeroyd, J. Lutz, K., Beckett, A. (2012). Exclusion and Control: Patterns aimed at limiting the influence of faculty of color. Journal of Nursing Education, 51(6), 314-325. https:// doi:10.3928/01484834-20120323-04

Hassouneh, D., Lutz, K. F., Beckett, A. K., Junkins, E. P., & Horton, L. L. (2014). The experiences of underrepresented minority faculty in schools of medicine. *Medical Education Online*, *19*(1), 247-268. https://doi.org/10.3402/meo.v19.24768

Hatch, S.L. & Dohrenwend, B.P. (2007). Distribution of traumatic and other stressful life events by race/ethnicity, gender, SES, and age: A review of the research. *American*

Journal of Community Psychology, 40, 313–332.

Hawkins, L., Fook, J. & Ryan, M. (2001). Social workers' use of the language of social justice. British Journal of Social Work, 31, 1-13.

Haynes, S. (2020, June 22). As protesters shine a spotlight on racial injustice in America the reckoning is going global. *Time.https://time.com/5851879/racial-injustice-protests-europe/*

Healthy People 2030. (n.d.). Social determinants of health. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Heckler, M. (1985). Report of the secretary's task force on Black & minority health. U.S. Department of Health and Human Services. https://www.minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf

Hefferon, K. & Ollis, S. (2006). 'Just clicks': An interpretive phenomenological analysis of professional dancers' experience of flow. Research in Dance Education, 7(2), 141-159.

Henne, K., & Shah, R. (2015). Unveiling White logic in criminological research: An intertextual analysis. *Contemporary Justice Review*, *18*, (2), 105–120. http://dx.doi.org/10.1080/10282580.2015.1025620

Heron, B. (2005). Self-reflection in critical social work practice: subjectivity and the possibilities of resistance. *Reflective Practice*, 6(3), 341-351. https://doi.org/10.1080/14623940500220095

Heron, B. (2007). *Desire for development: Whiteness, gender, and the helping imperative.* Wilfrid Laurier University Press.

Heyman, J. & Congrees, E. (Eds.). (2018). Health and social work: Practice, policy, and research. Springer Publishing Company.

Hicken, M., & Kravitz-Wirtz, N., Durkee, M. & Jackson, J. (2018). Racial inequalities in health: Framing future research. *Social Science & Medicine, 199,* 11–18. https://doi.org/10.1016/j.socscimed.2017.12.027

History of American Women. (n.d.). Black Civil War Nurses. https://www.womenhistoryblog.com/2014/11/black-civil-war-nurses.html

Hlavinka, E. (2020, June). Racial bias in Flexner report permeates medical education today. *MedPage Today.* *https://www.medpagetoday.com/publichealthpolicy/medicaleducation/87171*

Hollingsworth, L. D., Patton, D. U., Allen, P. C. & Johnson, K. E. (2018). Racial microaggressions in social work education: Black students' encounters in a predominantly White institution. *Journal of Ethnic & Cultural Diversity in Social Work*, *27*(1), 95-105.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, *113*(16), 4296–4301. https://doi.org/1 0.1073/pnas.1516047113

Holosko, M. J., Briggs, H. E., & Miller, K. M. (2018). Do Black Lives Really Matter—To Social Work? Introduction to the Special Edition. *Research on Social Work Practice*, *28*(3), 272–274.

Hopkins, H.L. (1926). The place of social work in public health. Paper presented at: National Conference of Social Work; May 26–June 2, 1926; Cleveland, OH. https://socialwelfare.library.vcu.edu/social-work/the-place-of-social-work-in-public-health/

hooks, b. (2015). *Feminist Theory: From Margin to Center*. Routledge.

hooks, b. (1994). Teaching to Transgress: Education as the Practice of Freedom. Taylor & Francis Group.

hooks, b. (1992). *Representing whiteness in the Black Imagination*. Routledge.

hooks, b. (1989). Talking back: Thinking feminist, thinking black. South End Press.

Hudson, K. D. (2017). With equality and opportunity for all? Emerging scholars define social justice for social work. *The British Journal of Social Work*, *47*(7), 1959-1978.

Hughey, M. (2016). Hegemonic whiteness: From structure to agency to identity allegiance. In S. Middleton, D. Shaffer & D. Roediger (Eds.), *The construction of whiteness: An interdisciplinary analysis of race and the meaning of a white identity* (pp. 212-233). University Press of Mississippi.

Human Impact Partners (n.d.). Disparity vs Inequity. Health Compass Milwaukee. http://www.healthcompassmilwaukee.org/tiles/index/display?alias=inequity

Ioakimidis, V. & Trimikliniotis, N. (2020). Making sense of social work's troubled past: Professional identity, collective memory, and the quest for historical justice. *British Journal of Social Work (2020)* 50, 1890–1908. https://doi: 10.1093/bjsw/bcaa040

Ignatiev, N. (1995). *How the Irish became white*. Routledge.

International Federation of Social Work (IFSWW). (n.d.). Global definition of social work. https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Issahaku, P. (2019). - *Anti-oppressive practice (AOP) as a social justice project in Canadian social work: Critical reflections*. SCWK 7020 Memorial University of Newfoundland Guest Lecture [PowerPoint Slides]. Retrieved from https://online.mun.ca/

Jackson J. & Weidman, N.M, & Rubin G. (2005). The origins of scientific racism. *Journal of*

Blacks in Higher Education, 50, 66-79.

Jaggers, G.(2003). That rare moment in history: A documented history of the formation of the National Association of Black Social Workers. Self-published. In the National Association of Black Social Workers, Inc. Collection, Beulah M. Davis Special Collections Room, Earl S. Richardson Library, Morgan State University, Baltimore, Maryland.

James, J. (2016). Forward. In Carten, A. Siskind, A., & Greene, M.P. (Eds.). (2016). *Strategies for deconstruction of racism in Health and Human Services*. Oxford Press.

James, K. & Jordan, A. (2018). The opioid crisis in Black communities. The Journal of Law, Medicine & Ethics, 46(2018), 404-421.

Jeffery, D. (2005). "What good is anti-racist social work if you can't master it?": Exploring a paradox in anti-racist social work education. *Race, Ethnicity and Education*, *8*(4), 409–425. https://doi.org/10.1080/13613320500324011

Jeyasingham, D. (2012). White Noise: A critical evaluation of social work education's engagement with whiteness studies. *British Journal of Social Work, 42(4),* 669-686.

Johnson, A.E. (1978). Roots:Reflections of the National Association of Black Social Workers ten years later. A week of history: NABSW, May 25-30, 1968. Confer- ence Proceedings of the Tenth National Conference of the National Association of Black Social Workers.Detroit, Michigan. In National Association of Black Social Workers, Inc. Collection, Beulah M. Davis Special Collections Room, Earl S. Richardson Library, Morgan State University, Baltimore, Maryland.

Johnson, K. (2021). Making space for students from widening access backgrounds: Socioeconomic diversity, historical contexts, and the need for reimagining of criteria and

culture within medical education.
https://blogs.bmj.com/medical-humanities/2021/10/07/

Jones, C.P. (2002). Confronting institutionalized racism. *Phylon, 50*(1), 7-22.
https://stacks.cdc.gov/view/cdc/104986

Jones, E.K. (1923). The Negro's struggle for health. In National Conference of Social Work. *Official Proceedings of the Annual Meeting*, *1923,* 68-72.
University of Chicago Press. http://name.umdl.umich.edu/ACH8650.1923.001.

Jones-Rogers, S. (2019). *They were her property: White women as slave owners in the American south.* Yale University Press.

Kennedy, A. C. (2008). Eugenics, "Degenerate Girls" and social workers during the Progressive Era. *Affilia: Journal of Women and Social Work, 23*(1), 22-37.
https://doi.org/10.1177/0886109907310473

Killian, J. (2021). Republican lawmakers take on diversity training, decry "indoctrination" at UNC-Chapel Hill. The Pulse. NC Newsline. https://ncnewsline.com/briefs/republican-lawmakers-take-on-diversity-training-decry-indoctrination-at-unc-chapel-hill/

Kimmel, M. & Ferber, A. (Eds.). (2017). *Privilege: A Reader* (4th ed.). Westview Press.

Kincheloe, J. L., Steinberg, S. R., & Chennault, R. E. (Eds.). (2000). *White reign: Deploying whiteness in America*. Palgrave Macmillan.

King, M.L. (1966). Dr. Martin Luther King on health care injustice. PNHP Associated Press Wire Story. https://pnhp.org/news/dr-martin-luther-king-on-health-care-injustice/#:~:text=King%20said%3A%20%E2%80%9CWe%20are%20concerned,often%20results%20in%20physical%20death.

King-Jordan, T. & Gil, K. (2021). Dismantling privilege and white supremacy in social work

education. Advances in Social Work, 21(2/3), 374-395.

Kirby, S. & McKenna, K. (2004). Methods from the margins. In Carroll, W. K. (Ed.). *Critical strategies for social research (pp. 67-74)*. Canadian Scholars' Press.

Kivel, P. (2017). *Uprooting racism: How white people can work for racial justice.* New Society Publishers.

Knight, R.J. (2021, January). African Americans, slavery, and nursing in the U.S. South. https://nursingclio.org/2021/01/07/african-americans-slavery-and-nursing-in-the-us-south/

Kolivoski, K. M., Weaver, A., & Constance-Huggins, M. (2014). Critical race theory: Opportunities for application in social work practice and policy. *Families in Society*, *95*(4), 269-276.

Lacasse, J. & Gomory, T. (2003). Is Graduate social work education promoting a critical approach to mental health practice? Journal of Social Work Education, 39(3), 383-408. https://doi.org/10.1080/10437797.2003.10779145

Ladson-Billings, G. (2003). It's your world, I'm just trying to explain it- Understanding our epistemological and methodological challenges. *Qualitative Inquiry, 9*(1), 5-12.

Ladson-Billings, G. (2013). Chapter 3 Critical Race Theory: What it is not! In Lynn, M., & Dixson, A. D. (Eds.). (2013). Handbook of critical race theory in education. Taylor & Francis Group.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*, 102-120.

Laws, T. (2021, March). How should we respond to racist legacies in health professions education originating in the Flexner Report? *AMA Journal of Ethics*.

https://journalofethics.ama-assn.org/article/how-should-we-respond-racist-legacies-health-professions-education-originating-flexner-report/2021-03

Leavy, P. (2014). Introduction. In Leavy, P. (Ed.), *The Oxford Handbook of Qualitative Research* (pp. 1-16). Oxford Press.

Leavy, P. (2017). *Research Design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches*. The Guilford Press.

Lee, E. (2014). Introduction: Race and the Relevance of Embodiment. In E. S. Lee (Ed.), *Living alterities: Phenomenology, embodiment, and race, (pp. 1-18). SUNY Press.*

Lee, E. & Bhuyan, R. (2013). Negotiating within whiteness in cross-cultural clinical encounters. Social Services Review, 87(1), 96-130. http:// doi:10.1086/669919.

Leonard, S. A., Main, E. K., Scott, K. A., Profit, J., & Carmichael, S. L. (2019). Racial and ethnic disparities in severe maternal morbidity prevalence and trends. *Annals of Epidemiology*, *33*, 30–36. https://doi.org/10.1016/j.annepidem.2019.02.007

Leonardo, Z. (2013). *Race frameworks: A multidimensional theory of racism and education.* Teachers College Press.

Leonardo, Z. (2004). The color of supremacy: Beyond the discourse of “white privilege.” *Educational Philosophy and Theory, 36*(2), 137-152.

Lerner, G. (Ed.). (1972). *Black women in White America: A documentary history*. Random House.

Lewis, R.E. (1937, June). Medical social work in 1937. *Bulletin of the American Association of Medical Social Workers*.

Leung L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of family medicine and primary care*, *4*(3), 324–327. https://doi.org/10.4103/2249-

4863.161306

Levitsky, S. & Ziblatt, D. (2020, September). End minority rule: Either we become a truly multiracial democracy or we cease to be a democracy at all. *The New York Times.* https://www.nytimes.com/2020/10/23/opinion/sunday/disenfranchisement-democracy-minority-rule.html

Library of Congress (LOC). (n.d.). Born in Slavery: Slave Narratives from the Federal writers' project, 1936-1938. https://www.loc.gov/collections/slave-narratives-from-the-federal-writers-project-1936-to-1938/about-this-collection/

Lipsitz, G. (2018). *The possessive investment in Whiteness: How white people profit from identity politics*. Temple University Press.

Lopez, I.H. (2010) Post-racial racism: Racial stratification and mass incarceration in the age of Obama. *California Law Review, 98*(3), 1023-1074.

Lopez, L.H. (2006). White by Law: The legal construction of race. (10th ed.). New York University Press.

Lorde, A. (1984). *Sister outsider: Essays and speeches. Crossing Press.*

Love, B. L., & Tosolt, B. (2010). Reality or Rhetoric? Barack Obama and Post-Racial America. Race, Gender & Class, 17(3/4), 19–37. http://www.jstor.org/stable/41674749

Maglalang, D.D., & Rao, S. (2021). Theory's Cool, But Theory With No Practice Ain't Shit...: Critical Theories and Frameworks to Dismantle Racism in Social Work Education and Practice. *Advances in Social Work*, *21*(2/3), 672-689. http://journals.iupui.edu/index.php/advancesinsocialwork/article/view/24145

Maguire-Jack, K., Lanier, P., & Lombardi, B. (2020). Investigating racial differences in clusters of adverse childhood experiences. *American Journal of Orthopsychiatry,* 90,106–114.

Maher, F. & Tetreault, K. T. (1998). They got the paradigm and painted it white: Whiteness and pedagogies of positionally. In Kincheloe, J., et al. (Eds.). White Reign: Deploying whiteness in America. St. Martin's Press.

Marcelin, J.R., Siraj, D.S., Victor, R., Kotadia, S., & Maldonado, Y.A. (2019). The impact of unconscious bias in healthcare: How to recognize and mitigate it. *Journal of Infectious Disease, 220*(Supplement_2), S62-S73.https://doi: 10.1093/infdis/jiz214.

Marcus, J. (2023). Chilling footage shows white supremacist group Patriot Front marching through DC. Independent. Yahoo News. https://news.yahoo.com/chilling-footage-shows-white-supremacist-040050917.html

Margolin, L. (1997). *Under the cover of kindness: The invention of social work.* University of Virginia Press.

Matias, C., Mitchell, K., Garrison-Wade, D., Tandon, M. & Galindo, R. (2014) "What is Critical Whiteness Doing in OUR Nice Field like Critical Race Theory?" Applying CRT and CWS to Understand the White Imaginations of White Teacher Candidates. *Equity & Excellence in Education, 47*(3), 289-304. http://dx.doi.org/10.1080/10665684.2014.933692

Maylea, C. (2020). The end of social work. *The British Journal of Social work. 51*(2), 77-789. https://doi.org/10/1093/bjsw/bcaa203

McFarling, U. (2021). 'Health equity tourists': How white scholars are colonizing research on health disparities. *STAT*. https://www.statnews.com/2021/09/23/health-equity-tourists-white-scholars-colonizing-health-disparities-research/

McFarling, U. (2023). MRI scans reveal disparate impact of poverty and other 'toxic stress'

on brains of Black children. STAT. https://www.statnews.com/2023/02/01/brain-scans-reveal-disparate-impact-of-poverty-toxic-stress-on-black-children/?

McGhee, H. (2021). *The Sum of Us: What Racism Costs Everyone and How We Can Prosper Together.* One World.

McMahon, A. & Allen-Meares, P. (1992). Is social work racist? A content analysis of recent literature. *Social Work*, 37, 533–539.

McRae, E. (2018). Mothers of massive resistance: White women and the politics of white supremacy. Oxford University Press

Medlock, M., Weissman, A., Shucheng, S., Carlo, A., Zeng, M., Borba, C., Curry, M., & Shtasel, D. (2017). Racism as a Unique Social Determinant of Mental Health: Development of a Didactic Curriculum for Psychiatry Residents. *MedPortal, 13*(10618). https://doi.org/10.15766/mep_2374- 8265.10618

Medlock, M., Shtasel, D., Trinh, N., & Williams (Eds.). (2019). *Racism and psychiatry: Contemporary issues and interventions*. Humana Press.

Mensah, M. (2020, July 23). Majority Taxes: Toward Antiracist Allyship in Medicine. *Points of View, The New England Journal of Medicine, 383*(4), e23(1)-e23(2).

Metzl, J. & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science Medicine*, *103*, 126–133. https://doi:10.1016/j.socscimed.2013.06.032.

Metzl, J., & Roberts, D.E. (2014). Structural competency meets structural racism: race, politics, and the structure of medical knowledge. *Virtual Mentor, 16*(9), 674-690.

Metzl, J. (2009). *The protest psychosis: How schizophrenia became a Black disease*. Beacon Press.

Metzl, J. (2019). *Dying of whiteness*. Basic Books.

Mehra, R., Boyd, L. M., Magriples, U., Kershaw, T. S., Ickovics, J. R., & Keene, D. E. (2020). Black pregnant women "Get the most judgment": A Qualitative study of the experiences of Black Women at the intersection of race, gender, and pregnancy. *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health*, *30*(6), 484–492. https://doi.org/10.1016/j.whi.2020.08.001

Mignolo, W. (2009). Epistemic disobedience, independent thought and de-colonial freedom. *Theory, Culture & Society, 26*(7–8), 1–23. https://doi: 10.1177/0263276409349275

Miller, R. & Minton, C. (2016). Interpretative phenomenological analysis: A contemporary phenomenological approach. Boise State University ScholarWorks. https://scholarworks.boisestate.edu/cgi/viewcontent.cgi?article=1111&context=counsel_facpubs

Mills, C. (1997). *The racial contract.* Cornell University Press.

Moerer-Urdahl, T. & Creswell, J. (2004). Using transcendental phenomenology to explore the “Ripple Effect” in a leadership mentoring program. *International Journal of Qualitative Methods, 3*(2). https://sites.ualberta.ca/~iiqm/backissues/3_2/pdf/moerer.pdf

Morris, A. (2015). *The scholar denied: W.E.B. Du Bois and the birth of modern sociology.* University of California Press.

Morris, T. (2006). Social work research methods: Four alternative paradigms. Sage Publications.

Morrison, T. (2019). *The source of self-regard. Selected essays, speeches, and meditation.* Alfred A. Knopf.

Moustakas, C. (1994). *Phenomenological research methods.* Sage Publications.

Murray-Lichtman, A. & Elkassem, S. (2021). Academic voyeurism: The white gaze in social work. *Canadian Social Work Review / Revue canadienne de service social*, *38*(2), 179–205. https://doi.org/10.7202/1086125ar

Murray-Lichtman, A., Aldana, A., Williams, T. & Naseh, M., Deepak, A., Rountree, M. (2022a). Dual pandemics awaken urgent call to advance anti-racism education in social work: Pedagogical illustrations. *Journal of Ethnic & Cultural Diversity in Social Work*. https://doi.org/10.1080/15313204.2022.2070899.

Murray-Lichtman, A., Singh, R., & Slayter, E. (2022b). An overview of addiction treatment and the disability community in the United States. *InterSections in Practice, 2022*(16). National Associations of Social Workers (NASW) Specialty Practice Sections. https://www.socialworkers.org/Careers/Specialty-Practice-Sections/Intersections-in-Practice-Public.

National Association of Social Workers (NASW). (n.d.). Code of Ethics. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Association of Social Workers (NASW). (2020, December). New report provides insight into new social worker's demographics, income, and job satisfaction. https://www.socialworkers.org/News/News-Releases/ID/2262/New-Report-Provides-Insights-into-New-Social-Workers-Demographics-Income-and-Job-Satisfaction

National Association of Social Workers (NASW). (2021, June). Undoing racism through social work. NASW Report to the Profession on Racial Justice Priorities and Action. https://www.socialworkers.org/LinkClick.aspx?fileticket=29AYH9qAdXc%3D&portalid=0

National Institute of Health (NIH). (n.d.) Binding wounds pushing boundaries: African

Americans in Civil War medicine. *US. National Library of Medicine*. https://www.nlm.nih.gov/exhibition/bindingwounds/nursing.html

National Public Radio (NPR). (2021, November). When schools ban books. https://www.npr.org/2021/11/11/1054798508/when-schools-ban-books

National Public Radio (NPR). (2020, September). Trumps expands ban on racial sensitivity training to federal contractors. https://www.npr.org/2020/09/22/915843471/trump-expands-ban-on-racial-sensitivity-training-to-federal-contractors.

National Public Radio (NPR), Robert Wood Johnson Foundation, & Harvard T.H. Chan School of Public Health. (2017). Discrimination in America: Experiences and Views of African Americans, January 26 – April 9, 2017. Report in series Discrimination in America.

NBC News. (n.d.). Southlake: Inside a critical race theory battle. https://www.nbcnews.com/southlake-podcast

Nelson, A. (2011). Body and Soul: The Black Panther Party and the fight against medical discrimination. University of Minnesota Press.

Neubauer, B., Witkop, C. & Varpio, L. (2019). How phenomenology can help us learn from the experience of others. *Perspectives on Medical Education, 8*(2), 90-97. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6468135/

Newberry, A. (2012). Social Work and hermeneutic phenomenology. *Journal of Applied Hermeneutics, 2012*(4).

Newman, L. (1999). *White women's rights: The racial origins of feminism in the United States.* Oxford University Press.

Nieblas-Bedolla, E., Christophers, B., Nkinsi, N., Schumann, P. & Stein, E. (2020). Changing

how race is portrayed in medical education: Recommendations from medical students. *Academic Medicine*, *95*(12), 1802-1806. https//: doi: 10.1097/ACM.0000000000003496

Nnawulezi, N., Case, K. A., Settles, I. H. (2020). Ambivalent white racial consciousness: Examining intersectional reflection and complexity in practitioner graduate training. *Women & Therapy, 43*(3-4), 365-388.

Nowell, L., Norris, J.M., White, D., & Moules, N. (2017). *International Journal of Qualitative Methods*, *16*, 1–13.

Obasogie, O. K., Harris-Wai, J. N., Darling, K., Keagy, C., & Levesque, M. (2015). Race in the life sciences: An empirical assessment, 1950-2000. *Fordham Law Review, 83*, 3089-3114. https://ir.lawnet.fordham.edu/flr/vol83/iss6/9/

Office of Disease Prevention and Health Promotion (ODPHP). (n.d.). Health care access and quality. *U.S. Department of Health and Human Services*. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/evidence-based-resources

Omi, M. & Winant, H. (2019). Racial Formations. In T. E. Ore, (Ed.), *The Social Construction of Difference and Inequality: Race, Class, Gender, and Sexuality.* Oxford University Press.

Owens, D.C. (2017). Medical Bondage: Race, gender, and the origins of American gynecology. The University of Georgia Press.

Owens, D.C. & Fett, S.M. (2019). Black Maternal and Infant Health: Historical Legacies of Slavery. *American Journal of Public Health 109*, 1342-1345, https://doi.org/10.2105/AJPH.2019.305243

Osborne, J. W. (1994). Some similarities and differences between phenomenology and other research methods of psychological qualitative research. Canadian psychology, 35(2),

167-189.

Park, Y. (2006). Constructing Immigrants: A historical discourse analysis of the representations of immigrants in U.S. social work, 1852-1952. Journal of Social Work 6(2), 169–203.

Pascal, J. (2010). Phenomenology as a research method for social work contexts: Understanding the lived experience of cancer survival. *Currents: New Scholarship in the Human Services*, *9*(2), 1–23.

Patton, M. Q. & Cochran, M. (2002). A guide to using qualitative research methodology. *Medecins Sans Frontieres.* *https://evaluation.msf.org/sites/evaluation/files/a_guide_to_using_qualitative_research_methodology.pdf*

Peller, G. (2016). Critical Race Consciousness: Reconsidering American Ideologies of Racial Justice. Routledge.

Perez, K. (2019). A critical race and disability legal studies approach to immigration law and policy. *Law Meets World. UCLA Law Review*. https://www.uclalawreview.org/a-critical-race-and-disability-legal-studies-approach-to-immigration-law-and-policy/

Perry, P., & Shotwell, A. (2009). Relational understanding and white antiracist praxis. *Sociological Theory, 27*(1), 33-50.

Phelan, J. C. & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? Annual Review Sociology, 41, 311-330. https:// doi.10.1146/annurev-soc-073014-112305

Poole, K. G., & Brownlee, D. (2020). Exploring the Current State of Racial and Ethnic Minorities in Healthcare Leadership. *Physician Leadership Journal*, *7*(5), 40–43.

Poulain R. (n.d.) Making Health Equity Visible: Results and Recommendations from the

Unnatural Causes User Survey. *Unnatural Causes*. http://www.unnaturalcauses.org/survey.php.

Praglin, L. (2007). Ida Cannon, Ethel Cohen, and Early Medical Social Work in Boston: The Foundations of a Model of Culturally Competent Social Service. *Social Service Review, 81*(1), 27-45. doi:10.1086/511013

Printz Pereira, D., Dominguez Perez, S., & Milan, S. (2023). U.S. mothers' appraisals of the race-related events of 2020: Implications for the course of maternal posttraumatic stress disorder symptoms. *Journal of Traumatic Stress, 36*(2), 272–284. https://doi.org/10.1002/jts.22904

Profiles in Black medicine. (2008, Feb 13). *Hyde Park Citizen.* http://libproxy.lib.unc.edu/login?url=https://www.proquest.com/newspapers/profiles-black-medicine/docview/367558669/se-2?accountid=14244

Puzan, E. (2003). The unbearable whiteness of being (in nursing). Nursing Inquiry 10(3), 193-200.

Rabelais, E. & Walker, R., (2020). Ethics, health disparities, and discourses in oncology nursing's research: If we know the problems, why are we asking the wrong questions? *Journal of Clinical Nursing. https://doi.org/10.1111/jocn.15569*

Ray, R. (2021, January). How we rise: What the Capitol insurgency reveals about white supremacy and law enforcement. Brookings. https://www.brookings.edu/blog/how-we-rise/2021/01/12/what-the-capitol-insurgency-reveals-about-white-supremacy-and-law-enforcement/

Ray, R. & Gibbons, A. (2021, November). Why are states banning critical race theory? Brookings. https://www.brookings.edu/blog/fixgov/2021/07/02/why-are-states-

banning-critical-race-theory/

Razack, N. & Jeffery, D. (2002). Critical Race discourse and tenets for social work. *Canadian Social Work Review 19*(2), 257-271.

Razack, S. (1998). Looking white people in the eye: Gender, race, and culture in courtrooms and classrooms. University of Toronto Press.

Reichert, K. (1965). Social work's responsibility in community health, paper presented at Southern Regional Institute, National Association of Social Work, Nashville, TN, June 13.

Reisch, M. (1988). The uses of history in teaching social work. *Journal of Teaching in Social Work*, *2(*1), 3-16. https:// DOI: 10.1300/J067v02n01_02

Reisch, M. (2007). Social justice and multiculturalism: Persistent tensions in the history of US social welfare and social work. *Studies in Social Justice, 1*(1), 67–92.

Reisch, M. (2008). From melting pot to multiculturalism: The impact of racial and ethnic diversity on social work and social justice in the U.S. *British Journal of Social Work*, *38*(4), 788–804.

Reisch, M. (Ed.). (2014). *The International Handbook of Social Justice*. Routledge.

Reisch, M. (2017, October 10). Social Work and Social Justice: Past, Present, and Future. Keynote Address, 100th Anniversary Celebration University of Pittsburgh, School of Social Work, October 10, 2017.

Reisch, M. (2019). The interpretation of social justice, equality and inequality in social work: A view from the US. In Payne, M. & Reith-Hall,

Reisch, M. & Andrews, J. (2002). *The road not taken: A history of radical social work in the United States.* Brunner-Routledge.

Reisch, M. & Andrews, J. (1999). Uncovering a Silent Betrayal: Using Oral History to Explore the Impact of Mccarthyism on the Profession of Social Work in the United States. *The Oral History Review, 26*(2), 87-106. https://www.jstor.org/stable/3675591

Ricks, T. N., Abbyad, C., & Polinard, E. (2021). Undoing racism and mitigating bias among healthcare professionals: Lessons learned during a systematic review. *Journal of Racial and Ethnic Health Disparities,* 1–11. Advance online publication. https://doi.org/10.1007/s40615-021-01137-x

Roberts, D. (1995). Punishing drug addicts who have babies: Women of color, equality, and the right of privacy. In Crenshaw, K., Gotanda, N., Peller, G., & Thomas, K. (Eds.), *Critical Race Theory: The key writings that formed the movement.* The New Press.

Roberts, D. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty*. Vintage Books.

Roberts, D. (2011). *Fatal Invention*. The New Press.

Roberts, D. (2017). What's race got to do with medicine? In Raz, G., National Public Radio, *Ted Radio Hour.* https://www.npr.org/transcripts/514150399

Roberts, J. (2021, June). Pandemics and protests: America has experienced racism like this before. Brookings. https://www.brookings.edu/blog/how-we-rise/2021/06/09/pandemics-and-protests-america-has-experienced-racism-like-this-before/

Roberts, L. (2013). Becoming a Black researcher: Reflections on racialised identity and knowledge production. *International Review of Qualitative Research, 6*(3), 337-359. https://www.jstor.org/stable/10.1525/irqr.2013.6.3.337

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress

disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*(1), 71–83. https://doi.org/10.1017/S0033291710000401

Roediger, D. (2007). The Wages of Whiteness: Race and the making of the American working class. Verso.

Roithmayr, D. (2014). *Reproducing racism: How everyday choices lock in white advantage.* New York University Press.

Rosenberg, G. & Rehr, H., (1983) *Advancing social work practice in the health care field*. The Haworth Press.

Ross, E. (Ed.). (1978). *Black heritage in social welfare: 1860-1930.* The Scarecrow Press, Inc.

Ross, J.W. (1995). Hospital social work. In R.L. Edwards (Ed.), *Encyclopedia of Social Work* (19th ed.), pp. 1365–1376. NASW Press.

Rubin, A., & Babbie, E.R. (2016). *Research methods for social work* (9th ed.). Cengage Learning.

Ruth, B. & Marshall, J. (2017). A history of social work in public health. *American Journal of Public Health, 107*, S236-S242. https://doi.org/10.2105/AJPH.2017.304005

Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity. Child Trends, https://www.childtrends.org/publications/ prevalence-adverse-childhood- experiences-nationally-state-race- ethnicity/

Seltzer, M. & Haldar, M. (2015). The other Chicago school - a sociological tradition expropriated and erased. *Nordic Social Work Research, 5*(1), S25–S41.

http://dx.doi.org/10.1080/2156857X.2015.1067638

Said, E. (1997). *Covering Islam: How the media and the experts determine how we see the rest of the world,* p. 157. Vintage.

Santiago, A. M. & Ivery, J. (2020). Removing the knees from their necks: Mobilizing community practice and social action for racial justice, *Journal of Community Practice, 28*(3), 195-207. https://doi.org/10.1080/10705422.2020.1823672

Scammell, J., & Olumide, G. (2012). Racism and the mentor-student relationship: Nurse education through a white lens. *Nurse Education Today, 32*(5), 545-550. https://doi.org/10.1016/j.nedt.2011.06.012.

Scarnato, J. M. (n.d.). Qualitative or quantitative research in social work. https://mswcareers.com/quantitative-research-in-social-work/

Schalk, S.D. (2022). *Black Disability Politics*. Duke University Press.

Schiele, J. (2017). The Afrocentric paradigm in social work: A historical perspective and future outlook. Journal of Human Behavior in the Social Environment, 27(1-2), 15-26. http://dx.doi.org/10.1080/10911359.2016.1252601

Schiele, J. (2011). Social Welfare Policy: Regulation and Resistance Among People of Color. Sage Publications, Inc.

Schroeder, C. & DiAngelo, R. (2010). Addressing Whiteness in Nursing Education. *Advances in Nursing Science, 33* (3), 244-255. https://doi:10.1097/ANS.0b013e3181eb41cf.

Schuster, J.-P., Le Strat, Y., Krichevski, V., Bardikoff, N. and Limosin, F. (2011), Benedict Augustin Morel (1809–1873). *Acta Neuropsychiatrica*, 23: 35-36. https://doi.org/10.1111/j.1601-5215.2010.00506.x

Segrest, M. (1994/2019). *Memoir of a race traitor.* The New Press.

Shannon, B. E. (1970). Implications of white racism for social work practice. *Social Casework, 51*(5), 270-276.

Shavers, V.L., Bakos, A., & Sheppard, V.B. (2010). Race, ethnicity, and pain among the U.S. adult population. *Journal of Health Care for Poor Underserved, 21*(1),177–220.

Shostak, S., Bandini, J., Cadge, W., Donahue, V., Lewis, M., Grone, K., Trachtenberg, Kacmerek, R., Lux, L., Matthews, C., McAuley, M. Romain, F., Snydeman, Tehan, T., & Robinson, E., (2021). Encountering the social determinants of health on a COVID-19 ICU: Frontline providers' perspectives on inequality in a time of pandemic. Qualitative Research in Health, 1. https://doi.org/10.1016/j.ssmqr.2021.100001.

Silver, C. & Lewins, A, (2014). Computer-Assisted analysis of qualitative research. In P. Leavy (Ed.), *The Oxford handbook of qualitative research* (pp. 606-638). Oxford Press.

Slopen, N., Shonkoff, J.P., Albert, M.A., Yoshikawa, H., Jacobs, A., Stoltz, R. & Williams, D. (2016). Racial disparities in child adversity in the US: Interactions with family immigration history and income. *American Journal of Preventive Medicine, 50*, 47–56.

Snyder, J.E., Upton, R.D., Hassett, T.C., Lee, H., Nouri, Z. & Dill, M. (2023). Black representation in the Primary Care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Network Open, 6*(4):e236687. https://doi:10.1001/jamanetworkopen.2023.6687

Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* National Academies Press.

Smith, J., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage Publications.

Smith, J. & Osborn, M. (2015). Interpretative phenomenological analysis as a useful

methodology for research on the lived experience of pain. *British Journal of Pain, 9*(1),

Social Welfare History Group. (2023). Red Scares, Political Repression, and Social Work: Why Now? Bibliography of Scholarship in Social Welfare History, 102(1). https://www.southernct.edu/sites/default/files/a/sites/social-welfare-history-group/SWHG-Bibliography102v1-RedScare.pdf

Social Welfare History Project (n.d.a). Bertha Capen Reynolds. *VCU Social Welfare History Project.* https://socialwelfare.library.vcu.edu/reynolds-bertha-capen

Social Welfare History Project (n.d.b). Lillian Wald. *VCU Social Welfare History Project.* https://socialwelfare.library.vcu.edu/wald-lillian

Specht, H. & Courtney, M. (1995). Unfaithful Angels: How Social Work has abandoned its mission. Free Press.

Spencer, R., Pryce, J. & Walsh, J. (2014). Philosophical approaches to qualitative research. In P. Leavy (Ed.), *The Oxford handbook of qualitative research* (pp. 1-16). Oxford Press. 41-42.

Spivak, G. C. (1988). Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 271–313). University of Illinois Press.

Spring, K.A. (2017). Mary Eliza Mahoney: 1845-1926. National Women's History Museum. https://www.womenshistory.org/education-resources/biographies/mary-mahoney

Starks, H. & Trinidad, S. (2007). Choosing your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10). 1372-1380.

Stefani, A. (2015). *Unlikely dissenters: White Southern Women in the Fight for racial justice, 1920-1970*. Florida Scholarship Online.

https://doi:10.5744/florida/9780813060767.003.0005

Stefaniak, A., Mallete, R. & Wohl, M. (2020). Zero-sum beliefs shape advantaged allies support for collective action. *European Journal of Social Psychology 50,* 159-1275.

Strega, S. & Brown, L. (2015). *Research as resistance: Revisiting critical, indigenous, and anti-oppressive approaches* (2nd ed.). Canadian Scholars' Press.

Sullivan, S. (2014). *Good white people*. Suny Press.

Tascòn, S. & Ife, J. (2020). *Disrupting whiteness in social work. Disrupting whiteness in social work*. Routledge.

The Sullivan Report. (2004). Missing persons: Minorities in the health professions. The Sullivan Commission on Diversity in the Healthcare Workforce. https://campaignforaction.org/wp-content/uploads/2016/04/SullivanReport-Diversity-in-Healthcare-Workforce1.pdf

Thompson, C., Schaefer, E., & Brod, H. (2003). *White men challenging racism: 35 personal stories*. Duke University Press.

Thornton, J. (1923). Hospital social service and health: Social case method in health work. In National Conference of Social Work. *Official Proceedings of the Annual Meeting, 1923,* 23-27.

University of Chicago Press. http://name.umdl.umich.edu/ACH8650.1923.001.

Todd, S. (2011). "That Power and Privilege Thing:" Securing whiteness in community work. *Journal of Progressive Human Services, 22,* 117-134

Toldson, I. (2019). *No BS (bad stats): Black people need people who believe in Black people enough not to believe every bad thing they hear about Black people*. Brill Sense.

Torrance, H. (2018). Evidence, criteria, policy, and politics: The debate about quality and utility in educational and social research. In Denzin, N. & Lincoln, Y. (Eds), The Sage

handbook of qualitative research (5th ed.). Sage Publications.

Towe, V. L., May, L. W., Huang, W., Martin, L. T., Carman, K., Miller, C. E., & Chandra, A. (2021). Drivers of differential views of health equity in the U.S.: is the U.S. ready to make progress? Results from the 2018 National Survey of Health Attitudes. *BMC public health*, *21*(1), 175. https://doi.org/10.1186/s12889-021-10179-z

Tuohy, D., Cooney, A., Dowling, M., Murphy, K, & Sixmith, J. (2013). An overview of interpretive phenomenology as a research methodology. *Nurse Researcher, (20*)6, 17-20.

Uluğ, Ö. M., & Tropp, L. R. (2021). Witnessing racial discrimination shapes collective action for racial justice: Enhancing awareness of privilege among advantaged groups. Journal of Applied Social Psychology, 51(3), 248–261. https://doi.org/10.1111/jasp.12731

Valdez, R. B. (2017). Blatant, subtle, and insidious: URM faculty perceptions of discriminatory practices in predominantly white institutions. *Sociological Inquiry, 87*(2), 207-232. http://dx.doi.org.libproxy.lib.unc.edu/10.1111/soin.1214

Villarosa, L. (2019). Myths about physical racial differences were used to justify slavery—and are still believed by doctors today. The 1619 Project. *The New York Times Magazine*. https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html

Wagner, D. (2005). The poorhouse: America’s forgotten institution. Rowman Littlefield Publishers. https://socialwelfare.library.vcu.edu/issues/poor-relief-almshouse

Walter-McCabe, H. (2020). Coronavirus Pandemic Calls for an Immediate Social Work Response. Social Work in Public Health, 35(3), 69-72. https://doi.org/10.1080/19371918.2020.1751533

Warren, M. (2010). *Fire in the heart: How white activists embrace racial justice.* Oxford

University Press.

Washington, H. (2006). *Medical Apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. Harlem Moon.

Washington, H. A., Baker, R. B., Olakanmi, O., Savitt, T. L., Jacobs, E. A., Hoover, E., Wynia, M. K., Writing Group on the History of African Americans and the Medical Profession, Blanchard, J., Boulware, L. E., Braddock, C., Corbie-Smith, G., Crawley, L., LaVeist, T. A., Maxey, R., Mills, C., Moseley, K. L., & Williams, D. R. (2009). Segregation, civil rights, and health disparities: the legacy of African American physicians and organized medicine, 1910-1968. *Journal of the National Medical Association*, *101*(6), 513–527. https://doi.org/10.1016/s0027-9684(15)30936-6

Watts, L. & Hodgson, D. (2019). *Social Justice Theory and Practice for Social Work: Critical and Philosophical Perspectives.* Springer.

Webb, C.B. (1931, February). Hospital social service in its relation to community welfare agencies. *Hospital Social Service*, *24*, 26.

Wells, A. O. (2004). Aaron O. Wells, MD and the Medical Committee for Human Rights: reflections on a life of conscience. *Journal of the National Medical Association*, *96*(11), 1519–1523. https://www-ncbi-nlm-nih-gov.libproxy.lib.unc.edu/pmc/articles/PMC2568609/

Wells-Barnett, I.B. (2002). *On Lynchings*. Amherst, Humanity Books.

Wenocur, S., & Reisch, M. (1989). *From Charity to Enterprise: The Development of American Social Work in a Market Economy*. University of Illinois Press.

Wertz, F. Charmaz, K. McMullen, L., Josselson, R., Anderson, R. & McSpadden, E. (2011). Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory,

discourse analysis, narrative research, and intuitive inquiry. The Guilford Press.

Wilding, C. & Whiteford, G. (2005). Phenomenological research: An exploration of conceptual, theoretical and practical issues. *Occupational Therapy Journal of Research OTJR: Occupation, Participation and Health, 25*(3), 98–104.

Williams, D, (2012). Miles to go before we sleep: Racial inequities in health. *Journal of Health and Social Behavior, 53*(3), 279-295. https:// doi:10.1177/0022146512455804

Williams, D.R., & Collins, C. (2001). Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Report, 116*, 404–416.

Williams, D., Lawrence, J. & Davis, B. (2019). Racism and Health and Needed Research. *Annual Review of Public Health, 40*, 105-125. https://doi.org/10.1146/annurev-publhealth- 040218-043750

Willoughby, D. (2018). Running away from drapetomania: Samuel. A. Cartwright, medicine, and race in the antebellum south. *Journal of Southern History, 84*(3), 579-614.

Woofter, T.J. (1923). Organization of rural Negroes for public health work. In National Conference of Social Work. *Official Proceedings of the Annual Meeting*, *1923*, 72-75. University of Chicago Press. http://name.umdl.umich.edu/ACH8650.1923.001.

Woolf, S. Masters, R., Aron, L. (2021). Effects of the covid-19 pandemic in 2020 on life expectancy across populations in the USA and other high-income countries: Simulations of provisional mortality data. *BMI, 373*(n1343). http://dx.doi.org/10.1136/bmj.n1343

World Health Organization (WHO). Constitution of the World Health Organization. https://treaties.un.org/doc/Treaties/1948/04/19480407%2010-51%20PM/Ch_IX_01p.pdf

Wright, K., Carr, K., Akin, B. (2021). The whitewashing of social work history: How

dismantling racism in social work education begins with an equitable history of the profession. *Advances in Social Work, 21*(2/3), 274-297. http://journals.iupui.edu/index.php/advancesinsocialwork/article/view/2411 5

Wright, R.R. (1919). What does the Negro want in our Democracy? National Conference on Social Welfare. Official proceedings of the annual meeting: 1919. https://quod.lib.umich.edu/n/ncosw/ach8650.1919.001/556?page=root;rgn=full+text;size=100;view=image;q1=democracy+not+a+whiteocracy

Wright, K., Carr, K., & Akin, B. (2021). The whitewashing of social work history: How dismantling racism in social work education begins with an equitable history of the profession. *Advances in Social Work, 21*(2/3), 274-297. http://journals.iupui.edu/index.php/advancesinsocialwork/article/view/24115

Wright, R. (1940). Notes of a Native Son. Harper Perennial.
Wright, R.R. (1919). What does the Negro want in our Democracy? National Conference on Social Welfare. Official proceedings of the annual meeting: 1919. https://quod.lib.umich.edu/n/ncosw/ach8650.1919.001/556?page=root;rgn=full+text;size=100;view=image;q1=democracy+not+a+whiteocracy
Wright-Mendoza, J. (2019, April). Richard Wright helped bring mental healthcare to Harlem. *JSTOR Daily*. https://daily.jstor.org/richard-wright-helped-bring-mental-healthcare-to-harlem/

Yancy, C. (2020). COVID-19 and African Americans. *JAMA, 323*(19),1891–1892. https//: DOI:10.1001/jama.2020.6548

Yancy, G. (2021, July 17). Black Feminist “Back Talk” Anchors Resistance on Both Sides of the Atlantic. *Truthout. https://truthout.org/articles/black-feminist-back-talk-anchors-*

resistance-on-both-sides-of-the-atlantic/?eType=EmailBlastContent&eId=07db8379-6873-4cc0-86f7-dbf7d3dede93

Yancy, G. (2017). *Black bodies, white gazes: The continuing significance of race in America*, (2nd ed.). Rowman & Littlefield.

Yancy, G. (2014). White gazes: What it feels like to be an essence. In *Lee, E. S. (Ed.). Living alterities: Phenomenology, embodiment, and race (pp. 43-64). SUNY Press.*

Zahavi, D. (2019a). *Phenomenology: The basics.* Routledge.

Zahavi, D, (2019b). Applied phenomenology: Why it is safe to ignore the epochè. *Continental Philosophy Review.* https://doi.org/10.1007/s11007-019-09463-y

Zambrana, R. E., Harvey Wingfield, A., Lapeyrouse, L. M., Davila, B. A., Hoagland, T. L., &

ZIPPIA Career. (n.d.). Licensed social worker statistics and facts in the US. https://www.zippia.com/licensed-social-worker-jobs/demographics/

Zuberi, T. (2001). *Thicker than blood: How racial statistics lie.* University of Minnesota Press.

Appendix A: Email Script for Recruitment

Subject Line: Invitation to participate in study that aims to examine the experiences of white healthcare providers (doctors, health scientist/researchers**,** nurses, and social workers) who think their actions contribute to racial justice

Hello,

My name is Andrea Murray-Lichtman. I am a social worker and researcher in the United States and PhD candidate at the School of Social Work at Memorial University of Newfoundland and Labrador (MUNL). I am currently completing my doctoral research under the supervision of Dr. Sulaimon Giwa on the topic of white healthcare providers in the United States involved in racial justice work in healthcare.

If you identify as **white** and you are a **doctor, health scientist/researcher, nurse, or social worker**, and consider that you have been or **are involved in racial justice work**, as you define it, you are invited to participate in a study titled: *Examining the Experiences of White Healthcare Providers Involved in Racial Justice Work.* With your help, we hope to learn about your experiences with racial justice work and your thoughts/perspective about white people involved in racial justice work. The objective of this study is to inform racial justice efforts in healthcare which may contribute to decreasing health inequities among racialized people. This research is important because its findings will provide a framework for increasing white people's engagement in anti-racism work. Should you agree to participate, your identity will remain confidential. You will be asked to participate in a five-minute Qualtrics demographics survey and a one hour long recorded individual interview remotely via Zoom. The Qualtrics Survey link includes an eligibility screening component and a link to the informed consent. You may withdraw your consent to participate in the study up until your data has been anonymized and collated with other data. If you choose to withdraw from the study, please notify the Principal Investigator, Andrea Murray-Lichtman, via email at ajmurray@email.unc.edu or ajmurraylich@mun.ca.

If you do not meet these participation criteria or you are not interested in participation, you may pass this information along to others who might meet these research inclusion criteria. If you meet the participation criteria and choose to participate, you may pass this information along to others who might meet these research inclusion criteria. Please note that you are under no obligation to participate or to pass along this information for the recruitment of others. There

will be no reward for participation or sharing this information or penalty if you do not participate or if you do not provide this information to others.

If you have received this email through a colleague, work, professional network, or professional organization that you are a member of, your participation in this study is not a requirement, your participation is voluntary.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

If you would like to participate in this research study, please access the Qualtrics Link [URL here]. If you have any questions, please contact me by email or by phone. I appreciate your time and consideration!

Thank you,

Andrea Murray-Lichtman MSW, LCSW, PhD (c)
ajmurraylich@mun.ca or ajmurray@email.unc.edu
(919) 636-3097

Appendix B: Informed Consent

Informed Consent Form

Title: *Examining the Experiences of White Healthcare Providers Involved in Racial Justice Work*

Researcher:
Andrea Murray-Lichtman
PhD Candidate
School of Social Work
Memorial University of
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Supervisor:
Dr. Sulaimon Giwa
Assistant Professor
Associate Dean of Undergraduate Programs
School of Social Work
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sgiwa@mun.ca
(709)864-7940

Dear Potential Participant,

You are invited to take part in a research project entitled *"Examining the Experiences of White Healthcare Providers Involved in Racial Justice Work."* My name is *Andrea Murray-Lichtman*, and I am a *PhD candidate* in the *School of Social Work* at Memorial University of Newfoundland and Labrador. I am also a social worker in the United States. As part of my doctoral research, under the supervision of Dr. Sulaimon Giwa, I am conducting research on the topic of white healthcare providers who consider that their work contributes to racial justice.

Introduction:
This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Take time to read this carefully and to understand the information given to you. Please contact the researcher, *Andrea Murray-Lichtman*, if you have any questions about the study or would like more information before you consent.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Purpose of Study:
The objective of this study is to gain insight into the subjective experiences of white healthcare providers involved in racial justice work. The examination of racial justice work by white healthcare providers will address a gap in the literature around white people in healthcare who choose to be involved in work that contributes to racial justice. The research is significant because white healthcare providers who are involved in racial justice work are often left out of the racial justice narrative. Addressing this gap in the literature may further the aims of racial justice in healthcare and help to eradicate health inequities among racialized people.

What You Will Do in this Study:
Participants in this study will be asked to answer demographic questions on a Qualtrics survey which contains an eligibility screening component and participate in an interview conducted over Zoom that will be audio-recorded for transcription. Participants can skip demographic and interview questions or withdraw at any time during the Qualtrics survey or interview data collection. Data collected up to that point will be destroyed.

Length of Time:
Participants in this study will be asked to complete a five-minute demographic Qualtrics survey and a one-hour interview conducted over Zoom that will be audio-recorded for transcription.

Withdrawal from the Study:

- Participants can skip demographic and interview questions or withdraw at any time during the Qualtrics survey or interview data collection. Data collected up to that point will be destroyed.
- Participants can withdraw consent and request removal of their data up to 5 days after data collection has ended.
- Data collected **cannot be removed after 5-days past the interview.** After that point data will be anonymized and aggregated.

Possible Benefits:
a) By participating in this study, participants may be inspired to continue their racial justice work and aid in other white healthcare providers becoming involved in racial justice work. The research could impact the health inequities experienced by racialized people and thereby help white providers to reach their goals for racial justice in healthcare.
b) The scientific/scholarly community and society will benefit because this research will fill a gap in the literature on white healthcare providers involved in racial justice work. This research can be used to inform social work practice, community work, and policy aimed at health equity for racialized people and encourage white healthcare providers involvement in racial justice work.

Possible Risks:
There are potential psychological and emotional risks in this study. Some participants may experience discomfort, anxiousness and upset following the interview. If you experience any of distress, please utilize the resources provided below to contact a local counseling service or crisis line.

Open Counseling Hotlines
https://www.opencounseling.com/hotlines-us

Mental Health America
https://mhanational.org/get-involved/contact-us **or** 1-800-273-TALK (8255) to reach a 24-hour crisis center, or text MHA to 741741 at the Crisis Text Line.

National Alliance on Mental Illness (NAMI)
https://www.nami.org/help or 1-800-950-NAMI (6264)

Confidentiality:

The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use, or disclosure. This is not an anonymous study; however, data will be anonymized and aggregated ensuring identifying information is not used in documentation or discussion of results. The researcher will take all necessary steps to ensure the confidentiality of its participants by doing the following: data will be de-identified and identifying information stored separately and ensuring the safe storage of data during collection, analysis, and dissemination. The researcher will assign the self-selected pseudonym to participants during audio recording. Although the data from this research project will be published and presented at conferences, the data will be reported in aggregate form, so that it will not be possible to identify individuals. Moreover, the consent forms will be stored separately from the anonymized and aggregated data so that it will not be possible to associate a name with any given set of responses. If participants racial justice efforts are well known within the healthcare community, there is a small chance that you may be identifiable to other people on the basis of what you have said. Every reasonable effort will be made to ensure the anonymity of your data.

Recording of Data:
This study will use audio recording, and the researcher will remind you to turn off your camera on Zoom, if you do not wish to be video recorded. As applicable, the researcher will ask you to remove your screen name and type in your self-selected pseudonym before recording begins. Data will be transcribed from the Zoom audio-recording and anonymized. Audio recordings will then be destroyed.

Use, Access, Ownership, and Storage of Data:
- Zoom recordings will be stored on a secure password protected and dually authenticated server. After recordings are transcribed and transcripts checked for accuracy, Zoom recordings will be securely destroyed. Data will be stored electronically on secure password protected storage devices. Consent forms and any identifying information will be stored separately from the data in password protected files on encrypted devices.
- The researcher will have access to all the data and the supervisor may access the anonymized data.
- Data will be anonymized and retained and may potentially be used to answer another research question.
- All primary data resulting from scholarly activity must be retained for a minimum of five years, as required by Memorial University's policy on Integrity in Scholarly Research.

Third-Party Data Collection and/or Storage:
Data collected from you as part of your participation in this project will be hosted and/or stored electronically by Zoom Videoconferencing and Qualtrics and is subject to their privacy policy, and to any relevant laws of the country in which their servers are located. Zoom is compliant with PIPEDA/PHIPA: Canadian Data Protection regulations, including the Personal Information Protection and Electronic Documents Act (PIPEDA) and, locally, the Personal Health Information Protection Act (PHIPA). Further details about this can be located here:
https://explore.zoom.us/docs/doc/PIPEDA_PHIPA%20Canadian%20Public%20Information%20Compliance%20Guide.pdf. Qualtrics is HIPAA compliant and certified by Health Information Trust Alliance (HITRUST). Further details can be found here: https://www.qualtrics.com/platform/security/

Therefore, anonymity and confidentiality of data may not be guaranteed in the rare instance, for example, that government agencies obtain a court order compelling the provider to grant access to specific data stored on their servers. If you have questions or concerns about how your data will be collected or stored, please contact the researcher and/or visit the provider's website for more information before participating. The privacy and security policy of the third-party hosting data collection and/or storing data can be found at: Zoom https://explore.zoom.us/en/privacy/?zcid=1231 and Qualtrics https://www.qualtrics.com/privacy-statement/ . Dedoose privacy and security can be found at https://www.dedoose.com/about/security.

Reporting of Results:
The de-identified data will be reported using pseudonyms if any direct quotations are used and aggregated data may be summarized in the final report. Each participant can access the results of this study along with the final dissertation which will be deposited at the Memorial University Research Repository Social Work Thesis Collection: https://research.library.mun.ca/view/theses_dept/SchoolSocialWork.html. The archived data on this repository will remain anonymized.
Participants can access any other publications that emerge from this dissertation on my academia.edu page: https://unc.academia.edu/AndreaMurrayLichtman and researchgate: https://www.researchgate.net/

Questions:
You are welcome to ask questions before, during, or after your participation in this research. If you would like more information about this study, please contact: *Andrea Murray-Lichtman, email: ajmurraylich@mun.ca or her supervisor Dr. Sulaimon Giwa, email: sgiwa@mun.ca.*

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Online Consent Form:

Consent:

By completing this *survey* you agree that:

- You have read the information about the research.
- You have been advised that you may ask questions about this study and receive answers prior to continuing.
- You are satisfied that any questions you had have been addressed.
- You understand what the study is about and what you will be doing.
- You understand that you may choose not to answer any questions on the survey.
- You understand that you are free to withdraw participation from the study by closing your browser window or navigating away from this page, without having to give a reason and that doing so will not affect you now or in the future.
- You will be contacted by the researcher to complete a virtual Zoom one-hour interview. At the beginning of the virtual interview, you will have another chance to ask questions. During the interview, you can skip interview questions or withdraw from the study at any time.

Regarding withdrawal after data collection:

- You understand that if you choose to withdraw, you may request that your data be removed from the study by contacting the researcher within *five days after your interview.*

By consenting to this online survey, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Please retain a copy of this consent information for your records. ** *You may download a copy of the PDF of the consent form [here]* **

Clicking *this box and continuing the survey* **below and submitting this survey constitutes consent and implies your agreement to the above statements.**

Appendix C: Qualtrics Demographic Survey Protocol

Thank you for your participation in this research study *Examining the Experiences of White Healthcare Providers Involved in Racial Justice Work. You may skip any questions that you do not wish to answer. Please be aware that skipping the eligibility screening questions (Questions 1 and 2) will end the survey and it is your right to do so. You are free to withdraw participation from the survey by closing your browser window or navigating away from this page, without having to give a reason and doing so will not affect you now or in the future.*

Do you identify as white?

- o Yes
- o Yes, and I identify with multiple racial identities. Please indicate racial identities:____________
- o No

Do you identify as a ________?

- o Doctor
- o Health-related scientist or researcher
- o Social worker or social work researcher
- o Nurse or nurse scientist
- o None of the above

If no or none of the above, [Qualtrics embedded skip logic ends survey]. *Thank you very much for your interest in participating in this study. It appears that you do not meet study eligibility requirements. If you think this is in error, please contact Andrea Murray-Lichtman via email: ajmurray@unc.edu or ajmurraylich@mun.ca*

If yes, move to next question.
Please click [here] to read the pdf consent to participate in this study. Please retain a copy of this consent information for your records. By continuing and completing this survey you agree that:

- You have read the information about the research.
- You have been advised that you may ask questions about this study and receive answers prior to continuing.
- You are satisfied that any questions you had have been addressed.
- You understand what the study is about and what you will be doing.
- You understand that you may choose not to answer any questions on the survey.
- You understand that you are free to withdraw participation from the study by closing your browser window or navigating away from this page, without having to give a reason and that doing so will not affect you now or in the future.
- You will be contacted by the researcher to complete a virtual Zoom one-hour interview. At the beginning of the virtual interview, you will have another chance to ask questions.

During the interview, you can skip interview questions or withdraw from the study at any time.

Regarding withdrawal <u>after</u> data collection:

- You understand that if you choose to withdraw, you may request that your data be removed from the study by contacting the researcher within *five days after your interview.*

By consenting to this online survey, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

To agree, consent, and continue click here [continue]. Completion and return of the survey will constitute consent to participate and implies your agreement to the above statements and gives permission for the researcher to use the data gathered in the manner described.

Please type in a pseudonym that you can be referred to throughout the study. (For instance, Joe, Jack, Flowerchild, etc.)__________________________________**You will be asked for this pseudonym at the beginning of your interview also. I request that you write it down so that you will remember it.**

Age:

- o 22-30
- o 31-40
- o 41-50
- o 51-60
- o 61-69
- o >70

What is your gender identity?

- o Female
- o Male
- o Non-binary
- o Non-gender conforming
- o Transgender
- o Self-describe:

What is your sexual orientation?

- o Asexual
- o Bisexual
- o Gay
- o Heterosexual or straight
- o Lesbian
- o Pansexual
- o Self-describe:

What would you estimate your socioeconomic status was during your childhood?
- Low socioeconomic status
- Middle socioeconomic status
- High economic status

Were you a first-generation college student?
- Yes
- No

How often do you interact socially with people of color (black people/BIPOC people)
- 2 or more times per week
- 1 time per week
- Infrequently
- Never

How engaged were your parents in social issues?
- Very involved
- Occasionally involved
- Not involved
- Do not remember

Were you exposed to racial justice information/conversations/actions as a child?
- Yes
- No
- Do not remember

Did your family regularly attend religious services during your childhood?
- Yes
- No
- Do not remember

Do you regularly attend religious services as an adult (pre-COVID-19)?
- Yes, one or more times per week
- Occasionally, one or more times per month
- Infrequently, once or twice per year
- No

Thank you for your participation in the electronic survey. Please click this [link] to schedule your interview with the researcher. If you have any difficulty or would prefer to schedule directly *please contact Andrea Murray-Lichtman via email: ajmurray@unc.edu or ajmurraylich@mun.ca or by phone (919) 636-3097.*

Appendix D: Research Instrument

Proposed General Questions

- *How would you define racism?*
- *How would you define racial justice work?*
- *Can you describe a time when you witnessed racism? How old were you? How did witnessing racism impact you? What did you say or do?*
- *How do you think racism and white supremacy has impacted racialized people's lives? How do you think racism and white supremacy has impacted white people?*
- *How do you think racism and white supremacy has impacted health care?*
- *Can you tell me your thoughts about the role of racism in health inequities for racialized people?*
- Can you tell me your thoughts about which racial group has the primary responsibility for solving racism?

Proposed Experience questions

- *What is your experience of racial justice work?*
- *Please describe the activities that you are involved in or your actions that contribute to racial justice.*
- *What event prompted your engagement with racial justice work?*
- *How did you decide what racial justice action to take?*
- *Who else is involved in your racial justice work? Are they white people, Black people, or other people of color?*
- What has been your experience working with Black people or other people of color in racial justice work?
- *How do you determine what is needed for your racial justice work?*
- *How does your social identity shape your experiences with racial justice work?*
- *How has your racial justice work impacted your life? Identity? Sense of self?*
- *How do you think your racial justice work has impacted the life of racialized people?*
- *What is the cost of being involved in racial justice work?*
- *What do you gain by being involved in racial justice work?*
- *How does your involvement in racial justice work impact your career?*
- *How does your involvement in racial justice work impact your family life?*
- *What is your investment in racial justice work?*
- What have been your personal challenges doing racial justice work?

- What have been your personal successes doing racial justice work?
- What makes you continue to do this work?
  What has been your experience working with Black people in racial justice work?
- How do you learn more about racial justice work?
- How do make sure you aren't playing into white supremacy or white saviorism?

Proposed Feedback Questions

- *What suggestions do you have around initiatives that could be taken up to address racial injustice?*
- *Is there anything else relating to the issues of racial justice work or white healthcare providers involved in racial justice work that you would like to discuss that I have not asked about?*