Reckoning With Racism in Nursing

Jitana Benton-Lee Transcript
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We're addressing racism in nursing.

I'm Jitana BentonLee

and I've been a nurse

for almost
years is getting pretty close.

I think in December it will be years.

I started out in the ICU,
so it was one of those new grads

that went directly from grabbing her

degree into the ICU.

I am a rural Kentuckian

I am AfricanAmerican.

I grew up in an area that was very poor.

It was very desolate.

The health care system was not very great.

My family owned a nursing home,

and so my great grandfather
started the nursing home

back in the fifties
when it was just for colored people.

And then in the eighties, of course,

it transitioned to everybody.

And so I was always around health care,

even though I didn't understand my family
kind of ran this nursing home.

I guess I just thought that I was there.

So I always had a, this affinity,

this attraction to nursing.

Of course
I had to go around the world to get there

because I developed an English degree,
I taught business administration.

And so I went back later
as a second degree nurse

and received a nursing degree
and very passionate about it.

I realized that that was
my purpose was nursing.

I found myself in a situation
where I was seeing more

and more of my loved ones
pass away from preventable illnesses.

For me, health care is strictly personal
because I wanted to be able

to go back into my community
and make a difference.

I felt like some of it was lack

of education in my community,

but also lack of resources

But then there's also discrimination

I was
in an area, in a hospital, in an area

that is has a majority
Caucasian population.

I was supposed to go into a room
and start an IV, something that I did

really, really well as a nursing student

when I went into the room.

He sent me out.

He said he didn't want an nword
to take care of him.

I was so disheartened

because I didn't expect that in a
in a health care environment to

to be called outside of my name.

I didn't know how to react.

I talked to my clinical instructor
and she said,

this is part of the process.

In one sense,
that's true. In another sense.

I don't ever think
a nurse needs to take any type of abuse.

We had a conversation with them

and he still kept
throwing the nword around.

And then he said that he had a fear

that I was going to give him nword blood

and that he didn't
want to turn into a nword.

I was in the process of crying.

I was trying to be strong.

I was with my peers,
and I was hearing my instructor say,

this is part of the process.

Her experience was different than mine.

In her mindset, being a nurse,

that's worked med surge, that patients call
you bad names all the time.

You know, they they they will
they will yell at you.

They will scream at you.

And she didn't say
the nword is being different than maybe

being called, you know, a bad word

or called a derogatory term for a woman.

I don't think

she saw the difference in that.

So she didn't know how to handle it.

But I also think that in her

lack of knowledge, she was uncomfortable.

I did end up drawing the blood
first stick after

multiple people tried him and couldn't
get it, even experienced nurses.

And he said nword,
you did a really good job.

I'm surprised.

When you're doing your job
and you're trying to save lives.

I always say, nurses, we save lives.

And someone cannot see the fact
that you're trying to help them

and they can only see
that you're a black person.

It's detrimental to your spirit.

I worked surgical

ICU for many years and loved it.

I did pediatric ICU

for a few years and cath lab
and then I decided

to try my hand in management,
and so I went into administration.

My biggest hurdle ever was trying

to climb
the administrative ranks in nursing

I became a manager

for sure, and that was extremely hard.

And then trying to go from
manager to director was almost impossible.

Some of the individuals that I trained

and provided

education to moved up ahead of me,

even though I realized that they didn't
necessarily have the skill set.

I think it was
because I was a person of color.

Some of the racism I faced

was from even my own nursing staff.

Working peer to peer was okay,

but once I became a leader

it was more difficult taking direction

or getting feedback,

even receiving performance evaluations
from a person of color.

And even if I communicated things

the same way as someone else,

they would say I was aggressive.

I was the highest paid nurse manager

because I had been there so long.

I had watched several of my peers

that did not have the same qualifications,
moved up.

What I learned to do
is that continue to apply,

and when I didn't get the position,

I would ask for a follow up meeting.

And in that follow up meeting,
I advocated for myself

and I asked for them to explain why
I didn't get the position

[I was] told that I didn't have

executive experience.

And I said,
I do have executive experience.

Remember this notebook?

I would create a portfolio of things
that I've done,

and I gave it to them
before the interview.

And I would slide the extra

copy that I kept across the desk
and flip through the pages.

I said, This is where
I had executive experience doing this.

This is where you sent me for training,
for executive experience.

This is where I trained
the last two individuals

who moved up with executive training,

and I wanted to make them know
that it was blatant,

that there were alternative reasons

why I wasn't being moved up.

No corrective action in my chart,

no attendance issues.

So why didn't you move me up?

I managed

a surgical and trauma unit
for about ten years

at an academic medical center.

And now I have shifted,
which is pretty exciting.

I've shifted to academia.

I do a lot of education to graduate.

So doctoral and master level
nursing students

I also run a nonprofit organization

here in Kentucky
that look, it's called Cultured

Remedy, where we do community based education.

Seeing what I saw growing up

and the health disparities
kind of prepared me for this.

I go in and provide
intercultural development training,

so I will test them to see where they're
current.

Intercultural development level is.

We'll talk about unconscious bias
because it's so important.

A lot of times people say I'm not racist,
but then they have behaviors

that exhibit it
and they're not aware of it.

I look at where they are
as far as being monoculture, focused

only on their culture
all the way up to world views.

And what I tell people
is that you have to get to the point

where you can adapt to other cultures
and still be true to yourself.

I'm rural, I'm Kentuckyian,
and that's who I am.

That's part of my culture.

However, I have to be able to learn

to interact with people
that are different for me.

If I'm going into your room with a patient

that may be of Muslim descent,

I need to be able to interact
with that patient in a way

that contributes
to their quality of health care.

And they're getting some ValueBased Care,

but we're also building a relationship
with each other.

I didn't take on their culture.

I still have mine, but I'm interacting

very well between the cultures,
and that's why

intercultural development
is so very important.

I'm so

nervous before I conduct any training,
and the reason

why is because either

three things will happen.

People will receive it
and they have that 'aha' moment

or they will be very confused.

And maybe they'll reach out
later to me to ask questions.

And those two things I'm very comfortable

with because I can adapt and adjust.

The third category is what I call
the scary category.

I'm a small, petite woman and I go in

and a lot of times
I get a lot of aggression.

Usually it's white males, but not always.

And they're very aggressive towards me,

and I kind of have to stick to my guns
and be very polite

but be steadfast
because I know this stuff.

Just because they disagree with me

doesn't mean what I'm saying is not true.

I usually start my presentation with

This is not your diversity
training from the nineties.

I always felt like in the eighties,
in the nineties, diversity

training was very polarization polarized

in that it's black against white,

heterosexual against homosexual,
you know, male against female.

I don't do that.

I feel like
we need to start bridging gaps.

So what I try to do
is paint the perspective in the beginning

before I even get into the heavy stuff

so that I am framing the discussion

to try to eliminate
some of that aggression.

But sometimes it still happens.

What I do want them to understand

is that even though

we're focusing on this minority group,
whatever

it is of this vulnerable population,

they are things that happen in all groups.

But today we're focusing on this group
because they have

the greatest hurdle to overcome.

And so when I start that sometimes

people hear it
and they try to take that perspective

Initially during

the presentation,
she was very kind of stoic very quiet.

But I started to see her come down

as we were starting to talk about things.

She was starting to internalize
and started to think about her experience.

I felt like at times
that she might have been weeping.

I couldn't quite see
because she was very guarded.

At the break, I talked to the staff

at the organization that I was working
with to kind of talk to her

and feel her out because she may not
feel comfortable with me coming to her.

They came back to me and said that

she feels very attacked,
that I was attacking her,

even though everything that I was saying

was very general to the group.

She was at times weeping,
but by the end of the session

she became so upset

and screaming and yelling at me.

We were talking about the differences

of care for racial minorities
and how AfricanAmericans

tend to fare worse with pain.

There's a recent study out
that health care providers

still believe
that black people don't have pain.

And so we were discussing that.

And she became so angry

with it
because she believed that that was true.

And that's what she was taught.

And I was wrong.

And at that point,
her frustration was that

I was incompetent
and sometimes as a person of color,

even when you're right,

people want to make you feel
like you're incompetent.

The first thing we have to do
is be selfaware of who we are.

In some environments, I'm privileged,
in some environments I'm oppressed.

And we have to be aware of that.

And we have to be able
to look at who we are and our biases

and make adjustments.

I think health care has grown so fast,
and it's boomed,

that we're so busy that

we can't connect with people

on a level of the heart.

Most of us went into nursing

because we were passionate
about taking care of people.

It's important for us to take
our leadership and our nurturing to change

health care in a way that we connect
to people on a very personal level.

I call it the village mentality,
so as nurses

we have to look at ways

to create social justice.

Nurse to patient. Nurse

to nurse.

Nurse
to provider and within our health systems.

And we can start small and build up.

As nurses and health care providers,

we expect for the patients to come to us.

Some communities
they don't know when they're ill.

They're used to using home remedies

in order to one, change racism
and to change

health care reform.

We're going to have to go back
into the communities

We're going to have to be seen
we're going to have to be heard

and we have to be their friends
and their family.

And we have to show compassion.

We can't sit in our pretty little million

dollar buildings and say

they need to come to us

because they may not be able to afford it.

I think the biggest thing
is accessibility.

And it has to look much, much different.

The pretty buildings is equality.

Equity is going to be community based,

and we need to provide equitable care