Examining Whiteness in Obstetric and Pediatric Simulations: A Content Analysis

Jessica Lamberson, DNP, RNC-OB, CNL; Pamela Pearson, DNP, APN, CNM; Natasha Crooks, PhD, RN; and Paige Ricca, DNP, MS, MBA, RN

ABSTRACT

Background: Whiteness is a systemic construct that functions to make itself invisible and prevent its racialization. Whiteness informs the nursing profession on all levels and impacts how nurses learn, relate to, and perpetuate whiteness through structural, curricular, interpersonal, and ideological means. The aim of this study was to use an antiracist framework to analyze manifestations of whiteness in select prelicensure obstetric and pediatric clinical simulation scenarios at a large midwestern college of nursing. **Methods:** Nine prelicensure nursing simulations were analyzed for themes using qualitative content analysis. **Results:** Two themes related to whiteness emerged from the data—normalizing whiteness in assessment and othering. **Conclusion:** Applying an antiracist framework in clinical nursing education can assist educators and students to see the embedded whiteness and racism in the curriculum and begin to address it. Additional analysis is needed to explore nurse educators and student perceptions of whiteness in simulations. **[*J Nurs Educ*. 2021;60(12):690-696.]**

The coronavirus disease 2019 pandemic has revealed and widened the gap in health disparities among Black and Brown communities as they have been disproportionately impacted. In the current climate of the pandemic and ongoing racial injustice, highlighted by the Black Lives Matter movement in recent years, the nursing profession has been confronted with its role in maintaining racism and inequity. It is imperative that nurses understand how nursing and nursing education has historically and is currently situated within this context and develop ways to address racism by incorporating social justice and antiracism within curricula. Villarruel and Broome (2020) ask us to consider hidden messages within nursing curricula that reinforce or discount racism and how they speak to what nursing faculty deem as important. This article attempts to confront the often hidden concept of whiteness and presents one way in which to reimagine nursing education to affect change in our profession.

Whiteness is a systemic construct, rooted and operationalized in maintaining racial hierarchy through power and oppression. By definition, whiteness functions to normalize and neutralize itself, defining all that is not white as other, deficient, and less than (Bell, 2021; Puzan, 2003). As a key tool of oppression rooted in white supremacy, whiteness plays a critical role in promoting and perpetuating social inequities, violating ethical standards in nursing and health care (E. Rabelais, personal communication, October 1, 2019). Inherent in the power structure of colonization and white supremacy, whiteness is and has been a feature of the nursing profession. The positionality and innate privilege of whiteness prevents the racialization of whiteness, effectively erasing white as a racial category (Puzan, 2003). As it does in society, whiteness infuses and informs the nursing profession on all levels, including education, research, practice, and policy; in turn, impacting how nurses learn, interact with, relate to, and perpetuate whiteness (Holland, 2015). Nursing maintains whiteness and structural racism through multiple "domains of power;" power exercised through structural, curricular, interpersonal, and ideological means (Puzan, 2003).

Nursing education is impacted by the overwhelming whiteness of the profession (Bell, 2021; Puzan, 2003). It is well documented that the nursing profession in the United States is predominated by white nurses, with approximately 73% of nurses (Health Resources and Services Administration [HRSA], 2019) and nearly 81% of nurse educators self-identifying as white (National League for Nursing [NLN], 2020). Approximately 10% of registered nurses identify as Hispanic, Latino, or Spanish, nearly 8% non-Hispanic Black, 5% non-Hispanic Asian, and 1.7% non-Hispanic multiracial (HRSA, 2019). American Indian or Alaska Native nurses constitute 0.3% of the nursing profession and Native Hawaiian or Pacific Islander 0.6% (HRSA, 2019). African American, Hispanic, and Asian nurse educators constitute 9%, 3.2%, and 2.7% of nurse educators, respectively (NLN, 2020). Less than 1% of nurse educators self-identify as multiracial (0.6%) or American Indian (0.4%) (NLN, 2020). Educators' and students' racial identities inform their conceptualizations of race and social justice, impacting

Jessica Lamberson, DNP, RNC-OB, CNL, is an Assistant Professor, Department of Nursing and Health Sciences, Elmhurst University. Pamela Pearson, DNP, APN, CNM, is a Clinical Assistant Professor, Department of Human Development Nursing Science, University of Illinois at Chicago, College of Nursing. Natasha Crooks, PhD, RN, is an Assistant Professor, Department of Human Development Nursing Science, University of Illinois at Chicago, College of Nursing. Paige Ricca, DNP, MS, MBA, RN, is a Clinical Assistant Professor, Department of Human Development Nursing Science, University of Illinois at Chicago, College of Nursing.

Address correspondence to Jessica Lamberson, DNP, RNC-OB, CNL, Department of Nursing and Health Sciences, Elmhurst University, 190 S Prospect Avenue, Elmhurst, IL 60126; email: jessica.lamberson@elmhurst.edu.

Disclosure: The authors have disclosed no potential conflicts of interest, financial or otherwise.

Received: May 1, 2021; Accepted: September 15, 2021

doi:10.3928/01484834-20211102-01

if and how they confront these concepts (Bell, 2021; Holland, 2015; Scammell & Olumide, 2012; Valderama-Wallace & Apeosa-Varano, 2019). Holland (2015) explains that the extent to which nursing instructors have lived and learned outside of white spaces and are familiar with academic race literature reflects their comfort with teaching about race and racism in nursing. Valderama-Wallace and Apeosa-Varano (2019) reveal that experiences and perceptions of whiteness, racism, and social justice in nursing practice and education diverge significantly along racial lines. White instructors tend to relate social justice to the ideals of equality and individualism, obscuring the concepts of equity and the structural factors integral to social justice and antiracism (Valderama-Wallace & Apeosa-Varano, 2019). Although distinct, equality and equity are interrelated concepts, both related to fairness. Equality is rooted in the idea of providing everyone the exact same resources or opportunities irrespective of individual needs. Instructors may interpret this action as being fair and just. The concept of equity involves distributing resources and opportunities based on the unique needs of each individual. The provision of resources is given based on a student's need (Gutoskey, 2020; Jean Paul, 2019). This is a significant factor in the facilitation of nursing education to support the specific learning needs and opportunities of all students.

Understanding and incorporating concepts of whiteness, antiracism, and decolonization into nursing education, practice, and profession is an ongoing, iterative process. It is a continual learning and unlearning of widely held, deeply rooted beliefs that are taught as foundational and uncompromising, which must be done at all levels of the profession, from individual nurses to institutions to structural levels of influence. A limited or absent understanding and conceptualization of whiteness and race in nursing restricts the degree to which nurses see whiteness and race as not only relevant to their practice and profession, but intricately bound to health and health outcomes. Additionally, authentic and critical self-reflection and examination, specifically by white nurse educators and students, is requisite to broadening one's understanding of race, whiteness, and their relevance to nursing, requiring both ongoing institutional support and individual commitment (Bell, 2021). Avoidance of such personal inquiry and responsibility runs the risk of externalizing the root of the problem and perpetuating the centering of whiteness in nursing (Bell, 2021).

Antiracist practice also includes actively challenging structural and interpersonal racism. It requires understanding the systemic origins of oppression and racism and how policies in education, practice, and professional organizations maintain oppression (McGibbon & Etowa, 2009). Nursing must gain a better understanding of the historical impact of colonialism, racism, and oppression on current nursing education, nursing practice, and perceptions and behaviors of nurses and nursing students (Waite & Nardi, 2019). Understanding how whiteness manifests in educational curriculum, such as clinical simulation documents, may help nursing schools, educators, and student see its impact and relevance to their practice and profession.

LITERATURE REVIEW

A literature search was conducted in the Cumulative Index to Nursing and Allied Health Literature database using the following term combinations: whiteness and nursing simulation, race and nursing simulation, and diversity and nursing simulation. The search was limited to peer-reviewed articles, available online, English only, and from 2010 to the present. The literature review revealed no articles specifically addressing whiteness in clinical simulation education; however, a paucity of evidence incorporating racial diversity and detailing the experience of minoritized students in the clinical simulation setting was found. Content analysis of whiteness and racism—whether implicit or explicit—in simulation scenarios has not been discussed in the literature. The aim of this study was to use an antiracist framework to analyze manifestations of whiteness in select prelicensure obstetric and pediatric clinical simulation scenarios at a large, urban Midwestern college of nursing.

THEORETICAL FRAMEWORK

The guiding conceptual framework used in this project is McGibbon and Etowa's (2009) "Anti-racist Framework to Guide Practice: Seeing, Understanding and Connecting, Acting." McGibbon and Etowa (2009) explain that antiracist practice is founded on three primary, interdependent processes: seeing, understanding and connecting, and acting. Antiracist practice begins with identifying the relationship between stereotypes and oppression, which are manifested in various forms of racism rooted in power dynamics and racial hierarchy. Once seen and acknowledged, understanding and connecting the pathways between oppression and policy that maintain racism is the next step in practicing antiracism. Antiracist action is the third process and results from the continuous processes of seeing, understanding, and connecting how racism is perpetuated at all levels of society. These processes are interrelated, interdynamic, and iterative. Although it is imperative to first "see" the connection between stereotype and oppression, it is possible to "see" more as understanding, connecting, and acting inform practice.

By applying this framework to the analysis of prelicensure nursing simulation scenarios, we are practicing antiracism by seeing and understanding how whiteness and racism is embedded in nursing education, including nursing pedagogy and praxis. Acknowledging that racism is maintained in our educational styles and strategies, compels us to interrogate the tools used to identify seen and unseen racist stereotypes, biases, and assumptions. This allows for revision of simulation documents, as well as opportunities to disrupt racist practices from persisting within nursing practice and health care in general.

METHODS

A purposive sample of four obstetric (OB) and five pediatric simulation cases were selected for this content analysis. Two of the OB cases were prepared using a standardized template by a national nursing organization, recognized by the International Nursing Association for Clinical Simulation and Learn-

ing. They include scenarios featuring postpartum hemorrhage and shoulder dystocia. Two cases were developed by a white, cisgender Master of Science in Nursing (MSN)-prepared OB woman instructor who has taught the prelicensure course for more than 4 years. Four of the five pediatric cases were also prepared by the same national nursing organization and describe three infant respiratory distress/respiratory failure scenarios and one child anaphylaxis case. The fifth case was developed by a white, cisgender MSN-prepared pediatric instructor with more than 6 years of pediatric clinical instructor experience. The specific cases were selected because they are the simulations most frequently used as part of the course content for prelicensure OB and pediatric clinical practicums at the target college of nursing. Qualitative content analysis was used to analyze textual data and its explicit or implicit contextual meaning (Hsieh & Shannon, 2005).

Data Analysis

The research team consisted of four authors from diverse backgrounds, all of whom are nurse educators. Three authors (J.L., P.P., P.R.) are experienced in clinical simulation education. The first author (J.L.) is a mixed-race Black woman with more than 20 years as a labor and delivery nurse, certified in inpatient obstetrics, and more than 6 years of experience teaching obstetrics to prelicensure nursing students. The second author (P.P.) is a Black woman nurse with more than 25 years of experience as a nurse midwife and more than 15 years as a clinical instructor for midwifery and women's health nurse practitioner students. The third author (N.C.) is a Black cisgender woman nurse with more than 5 years of research experience related to Black women sexual and reproductive health. The last author (P.R.) is a white cisgender woman nurse who has more than 23 years of pediatric and neonatal intensive care nurse experience and 3 years as a pediatric clinical instructor for prelicensure nursing students.

The authors implemented an inductive content analysis as described by Elo and Kyngäs (2008). The unit of analysis was nursing simulation transcripts which were read multiple times in their entirety to have a full picture of each scenario. "Open coding" allowed for making as many notes as necessary to "describe all aspects of the content" (Elo & Kyngäs, 2008) while reading through the text. The codes were compared and classified into sub-categories and further abstracted into main categories and themes (Elo & Kyngäs, 2008). The simulation transcripts were analyzed for both latent and manifest content. Manifest content refers to the explicit text within the simulation transcripts, while latent content is an interpretation of the underlying meaning of the text (Elo & Kyngäs, 2008; Graneheim & Lindman, 2004).

All initial coding and analysis were independently conducted by each author. Codes from individual analyses were then compiled and shifted across categories until group consensus was achieved. Trustworthiness of content analysis centers on the coding process and development of a coding scheme. To maintain trustworthiness, the authors discussed the texts, codes, subcategories, and categories throughout the analysis and interpretation process (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005).

RESULTS

Nine nursing simulation transcripts and associated documents were included in the analysis. Two primary themes emerged from the data: normalizing whiteness in assessment and othering. Within each theme, subcategories emerged and are listed with their descriptions in **Table 1**.

When analyzing the simulations, the theme "normalizing whiteness in assessment" emerged as any contextual information or data that incorporated clinical observations or written notes that inform the clinical picture. Physical assessment factors were the most predominant subcategory identified. Text in several simulation scenarios was related to skin and/or color assessment; however, emotional assessment and patient risk factors also emerged as subcategories. "Othering" included subcategories of explicit identification of race/ethnicity, stereotypes related to patients' race or ethnicity, and biased communication.

Normalizing Whiteness in Assessment

Among the analyzed simulation texts, the theme "normalizing whiteness in assessment" was most frequently identified. Assessment is the first step in the nursing process and a critical skill developed in nursing education through clinical and simulated patient care interactions. In the transcripts, pre-brief and simulation text provided assessment information to simulation participants in written report or verbal cues by simulation actors or voiced-over manikins. Subcategories for this theme highlighted how language can be used in physical assessment to assume or associate assessment findings with white, light, or "normal" skin. For example, in one evolving pediatric simulation scenario in which the patient's race or ethnicity is not identified, progress from the initial assessment and mild disease presentation to more severe progression is presented with the following assessment cues:

- "Warm extremities. Color normal."
- "She is pale and listless. . ." "Dark circles under eyes." "Mom is anxious during scenario and says, 'She's really sleepy, and she looks so pale!'"

In an OB simulation, the initial newborn assessment of a racially unidentified infant is prompted in the text and by the actors:

- "Attempt a brief newborn admission assessment. . . to include: Spine and back—examine for dimples, birthmarks, Mongolian spots"
- "Briefly explain APGAR score as it relates to acrocyanosis (normal finding)"
- "Why are her hands and feet kind of blue?"

Another pediatric simulation noted the "Caucasian (Hispanic)" patient's skin assessment as "pink, warm."

Understanding that physical manifestations of normal clinical conditions and disease processes differ among races and skin tones is important knowledge to have and a skill to develop. Neither pediatric simulation provides prompts to discuss appropriate skin assessment of children with varied skin color. Although acrocyanosis and birthmarks are normal and expected in newborns, the OB simulation lacks discussion on how to appropriately identify and assess the findings in newborns of all races and skin tones. It is also noted that the use and impli-

cation of the "Mongolian spot" assessment finding is incorrect clinical terminology.

The subcategory "risk factors" were identified in the facilitator guides of three simulations, but within two of the three scenarios, no risk factors were discussed throughout the scenario. Additionally, no instruction was provided to the facilitator on framing discussion around risk factors in the simulation debrief. One pediatric simulation transcript explicitly references race as a risk factor, albeit with absent discussion:

- "Although sudden infant death syndrome can strike any infant, researchers have identified several factors that may increase a baby's risk. They include: Race. For reasons that aren't well understood, Black, American Indian, or Eskimo infants are more likely to develop SIDS."

In health care and health outcomes dialogue, risk factors are often conflated with the patient's race rather than the systemic racism experienced by racialized people. Health care routinely fails to acknowledge that racism, not race, is a risk factor.

The "emotional assessment" subcategory emerged in three of the simulation cases. Inferences of social support compared between two OB simulations in which race was explicitly stated revealed that, in the simulation of an "African American" patient, although a husband was identified, he was not present nor mentioned in the discussion of support systems. Rather, a sister was identified and present as the support person in the simulation. In the simulation where the patient was identified as "Caucasian," the simulation text stated:

- "Major Support: husband"
- "Her husband has been present the entire stay and is very supportive, but concerned."

This quote is problematic as it suggests that white partners are more supportive and present in their partner's care than Black partners. It also assumes the "norm" is white and heterosexual, inherently othering any patient that does not identify as such.

In the same OB simulation that explicitly identified the patient as an "African American woman," the text reveals a lack of appropriate pain assessment and response in the following dialogue:

- "Oh hello—are you the nurse? I am glad you are finally here I have been in a lot of pain. I have been pushing the call button for a while."

This quote is problematic because it reinforces the common misconception that Black patients have a higher pain threshold than white patients, resulting in pain being inadequately treated in Black patients.

TABLE 1
Themes and Subcategories of Whiteness in Prelicensure Nursing Simulations

Theme	Subcategories
Normalizing whiteness in assessment	Physical assessment: Anything having to do with physical observations
	Risk factors: Any mention of risk factors or increased risk described or associated with health conditions mentioned
	Emotional assessment: Any description of support systems
Othering	Explicit: Statement of patient's race and/or ethnicity
	Stereotypes: Any potential bias specific to race and/or ethnicity
	Biased communication: Any reference of language other than English

Othering

The second major theme that emerged from the data was "othering," described as "exclusionary othering" by Canales (2000), the idea of separating or identifying difference from the accepted standard or social norm. Five of the simulations explicitly identified race and/or ethnicity as "African-American," "Caucasian," or "Caucasian (Hispanic)." Of the scenarios that listed race in the text or pre-brief, three did not include race in the body or dialogue of the actual simulation. One simulation labeled the race of the patient as "Caucasian (Hispanic)," conflating race with ethnicity, and did not provide discussion prompts on the difference between ethnicity and race.

The subcategory "stereotypes" emerged within this theme and encompassed assumptions or potential biases specifically related to race and/or ethnicity. Stereotypical representations serve to further perpetuate the idea of difference or "other" (Canales, 2000). In an OB simulation in which the patient's ethnicity was not identified but her surname and provided information implied Hispanic ethnicity, descriptive text and dialogue includes:

- "I am from a big family, and I love children; I can't wait to be a mom."
- [The patient] "eats a traditional Mexican-American diet."
- "When was your last appointment at the clinic?"

These quotes perpetuate stereotypes about family size and diet due to the patient's Mexican heritage. They also reference receiving care at a clinic, projecting a stereotypical association between ethnicity and use of a specific mode of care. The OB simulation that identified the patient as "African-American" included a patient quote, stating:

- "His name is Michael and he is much bigger than the girls—over 8 #'s [pounds]—my husband wants a son to play for the Bulls!"

This quote reinforces racial, gender, and physical stature stereotypes of African Americans being athletes. The association of a Black male infant with an adult basketball player fuels the stereotype of African Americans having innate athletic prowess and strength. Again, no tools were provided to guide discussion of racial or ethnic biases and stereotypes.

"Biased communication" was the final subcategory that emerged from the theme of "othering." It was present in one simulation scenario that indicated a pediatric patient's mother "will be. . . not overly communicative due to some limited

English." This statement may influence simulation participants' perception of non-English speaking patients and families. There was no framing or discussion provided for the facilitator to discuss the impact of a language barrier when providing care or the requirement to provide translation services to patients who request or require them.

DISCUSSION

We have organized our discussion according to the three stages of McGibbon and Etowa's (2009) "Antiracist Framework to Guide Practice: Seeing, Understanding and Connecting, Acting" to enhance seeing, understanding and connecting, and acting to inform nursing education, practice, and research. The results of the content analysis identified two primary themes related to whiteness within prelicensure nursing simulations: normalizing whiteness in assessment and othering. Both themes are rooted in the invisibility of the intersectional identities of individuals, but the normalization of whiteness. This prevents racialization of whiteness, making it an "objective" and standard baseline by which to compare physical assessment and social expectations or norms. Based on this normalization, assessments that do not align with the expected baseline are deemed different or othered.

Seeing

A critical first step in antiracist practice is identifying the relationship between stereotypes and oppression, ultimately understanding how racism is perpetuated and the invisibility of whiteness is maintained. The literature reviewed helps operationalize this step by highlighting the experiences and perspectives of minoritized nursing students in simulation settings and the impact of the presence or absence of racially diverse simulation facilitators (Graham et al., 2016; Graham et al., 2018) and manikins (Foronda et al., 2017; Foronda et al., 2020; Fuselier et al., 2016). One study revealed that nursing students felt that merely incorporating manikins of different colors in simulations did not increase their conceptions of cultural diversity or competency (Fuselier et al., 2016). However, minoritized students perceived an increased sense of inclusion with the incorporation of manikins of color (Fuselier et al., 2016), as well as an increased level of comfort and decreased anxiety in the simulation setting (Graham & Atz, 2015). Graham et al. (2018) found a positive impact on student participation in simulation activities when a minoritized simulation facilitator is present.

Other studies have highlighted the primacy of white simulation products used in or advertised for nursing school simulation scenarios (Foronda et al., 2017). Minoritized students reported the lack of diversity among simulation manikins, scenarios, and assessments aggravated feelings of underrepresentation (Graham & Atz, 2015). The use of primarily white manikins may create unfavorable conditions and negative outcomes for minoritized students (Graham et al., 2018). Additionally, minoritized students perceived discrimination from faculty, peers, nurses, and patients in clinical experiences (Graham et al., 2016). They felt labeled as unknowledgeable or underperforming in simulation experiences by peers and faculty, revealing issues of bias and discrimination issues at individual, program, and systems levels (Graham et al., 2016; Graham et al., 2018).

Although these studies have revealed different levels of racism in prelicensure nursing simulation education, it is also imperative to understand whiteness and how it functions to perpetuate the racial status quo. Recommendations from the literature include increasing racial diversity in simulation products and scenarios to foster inclusion and optimize learning (Foronda et al., 2017), diversifying simulation experiences and developing simulationists' capacity to facilitate and evaluate student participation (Graham & Atz, 2015), and acknowledging the "exclusive Eurocentric culture of nursing education" (Graham et al., 2016, p. 136).

Whiteness is pervasive yet invisible. By normalizing and neutralizing itself, it prevents itself from racialization and sees different races as other. Increasing racial diversity in simulation products and scenarios, without deeper analysis and reflection, is insufficient to disrupt patterns of whiteness and racism in nursing education. The findings of this content analysis examine ways in which whiteness and race are framed and "seen" in relation to each other. It is one step in helping nursing educators and students "see" the role of whiteness and its relationship to stereotypes, racism, and oppression. Revealing the invisibility of whiteness within simulation brings to attention how pervasive it is and how easily it is normalized.

Understanding and Connecting

Although seeing is the first process in antiracist practice, understanding and connecting the pathways between racism and whiteness and their embeddedness in policies, systems, and structures follow. Racism and whiteness are embedded in health care in general (Hoffman et al., 2016; Smedley et al., 2003; Tait & Chibnall, 2014) and the identified themes and subcategories demonstrate how they emerge in nursing simulation curriculum.

Within the simulation scenarios, descriptions of physical assessment findings showed a deference to white or light skin as a reference point. Additionally, the difference in the description of emotional support between a white and an African American patient was significant. Several of the scenarios identified a patient's race in the pre-brief, yet the text did not reference it during the simulation. Although it appears that there is nothing wrong or harmful with identifying a patient's race, it is curious to note if race is (1) critical to the care of the patient, (2) influences the simulation participants' perceptions or assumptions in the scenario, or (3) affects the content and dialogue of the simulation. Understanding and acknowledging the role race and racism play in health care and health disparities helps connect the path between implicit racial biases and well-documented differences in care based on race (Smedley et al., 2003). And, as previously noted, there is no guidance for the simulation facilitator to initiate this discussion with the students participating in the simulation.

The issues of delayed care, disbelief in pain level, and mismanagement of pain in Black patients is well document-

ed (Hoffman et al., 2016; Tait & Chibnall, 2014); however, neither these issues nor their impact on Black maternal morbidity and mortality were addressed in the simulation debrief. It also must be noted that the use and implication of the "Mongolian spot" assessment finding is dated and includes language rooted in biological racism (Zhong et al., 2019). A primary concern related to the simulations as a whole is the absence or minimal inclusion of guided discussion within the simulation documents. These must foster conversations around how assessment may vary and the historic roots of biological racism.

The concept of biological racism has been shown to persist among medical school students and residents (Hoffman et al., 2016) and nursing is not immune to the impact of such strongly held beliefs (Bell, 2021). Recent evidence has revealed how traditional tools and algorithms in health care have incorporated race, supporting the racist idea that race is an inherent risk factor and thus perpetuating biological racism (Vyas et al., 2020). The simulations do not provide the facilitator with guidance to broach the concept of biological racism and its impact on assessment tools and algorithms.

Acting

This content analysis is one application of antiracist action. Analyzing current simulation curricula for whiteness and racism reveals to nurse educators and nursing students what may have previously been unseen: normalization and centering of whiteness, conflation of race and ethnicity, and othering racialized patients. Once seen and identified, it is easier to help educators and students understand and make connections between whiteness and racism and acknowledge the importance of antiracist action. Beyond the specific text and language used in the simulations, we identified the lack of discussion guidance for simulation facilitators. This absence poses implications for how simulation debriefing documents can be developed and help build capacity for faculty to facilitate purposeful dialogue grounded in antiracist practice. One potential action would be to integrate antiracist principles and strategies in required simulation debrief training for all simulation instructors, calling out the racism embedded in clinical scenarios and nursing instructions. Another action would be to update simulation scenarios to provide a more holistic lens in which to view patient care, with an increased focus on factors outside of individual patient characteristics. For example, clinical educators could use simulations and debriefs to examine the impact of structural racism on patient-level care and health outcomes, helping students identify social and structural factors that need changing and develop strategies to effect change. Additional implications from this content analysis include the importance of self-reflexivity for instructors and students to process seeing, connecting, and understanding the role whiteness and racism has played in nursing (Bell, 2021; Holland, 2015; hooks, 1994; McGibbon et al., 2014; Puzan, 2003; Valderama-Wallace & Apesoa-Varano, 2019; Waite & Nardi, 2019). Nurse educators are encouraged to examine their own biases and determine how they impact their current teaching pedagogy and praxis.

STUDY LIMITATIONS

We also acknowledge that this content analysis is one attempt to cultivate and implement an antiracist nursing practice and share the process and results with the discipline. A few limitations in this study must be acknowledged. The small sample size ($N = 9$) in a single setting may not be a full and rich representation of OB and pediatric simulations used in prelicensure nursing education and limits transferability of findings. In addition, we could have strengthened the credibility of the analysis by incorporating feedback from students who participate in and other instructors who use the simulations. Lastly, the initial research team did not include an experienced qualitative researcher, which may have limited the analysis and negatively impacted the credibility of the findings.

CONCLUSION

This study reveals two themes related to whiteness in select OB and pediatric nursing simulations used in prelicensure clinical education. Applying an antiracist framework in clinical nursing education can facilitate educators' and students' process of seeing the embedded whiteness and racism in the curriculum. Strategies vary on how to address whiteness and racism, which are often hidden or invisible. However, evidence suggests that critical self-reflexivity is an essential component to address whiteness and colonialism (Bell, 2021; Holland, 2015; hooks, 1994; McGibbon et al., 2014; Puzan, 2003; Valderama-Wallace & Apesoa-Varano, 2019; Waite & Nardi, 2019). Furthermore, acknowledging and understanding the historical and social construction of race, its influence on the development of nursing, and the embedded racial associations that persist in the nursing profession informs antiracist practice at all levels of nursing: individual, interpersonal, organizational, and structural (McGibbon et al., 2014; Puzan, 2003; Waite & Nardi, 2019). These antiracist practices enable us to better critique the explicit and implicit messages in clinical simulations and what they communicate to nursing faculty and students (Villarruel & Broome, 2020). More research is needed to further explore the perceptions of the nurse instructors who use and nursing students who participate in the simulations.

References

Bell, B. (2021). White dominance in nursing education: A target for antiracist efforts. *Nursing Inquiry, 28*(1), e12379. https://doi.org/10.1111/nin.12379 PMID:32881135

Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science, 22*(4), 16–31. https://doi.org/10.1097/00012272-200006000-00003 PMID:10852666

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*, 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x PMID:18352969

Foronda, C. L., Baptiste, D., & Ockimey, J. (2017). As simple as black and white: The presence of racial diversity in simulation product advertisements. *Clinical Simulation in Nursing, 13*(1), 24–27. https://doi.org/10.1016/j.ecns.2016.10.007

Foronda, C. L., Prather, S. L., Baptiste, D., Townsend-Chambers, C., Mays, L., & Graham, C. (2020). Underrepresentation of racial diversity in simulation: An international study. *Nursing Education Perspectives, 41*(3), E12–E13. https://doi.org/10.1097/01.NEP.0000000000000511 PMID:32310909

Fuselier, J., Baldwin, D., & Townsend-Chambers, C. (2016). Nursing students' perspectives on manikins of color in simulation laboratories. *Clinical Simulation in Nursing, 12*(6), 197–201. https://doi.org/10.1016/j.ecns.2016.01.011

Graham, C. L., & Atz, T. (2015). Baccalaureate minority nursing students' perceptions of high-fidelity simulation. *Clinical Simulation in Nursing, 11*(11), 482–488. https://doi.org/10.1016/j.ecns.2015.10.003

Graham, C. L., Atz, T., Phillips, S., Newman, S., & Foronda, C. (2018). Exploration of a racially diverse sample of nursing students' satisfaction, self-efficacy, and perceptions of simulation using racially diverse manikins: A mixed methods pilot study. *Clinical Simulation in Nursing, 15*, 19–26. https://doi.org/10.1016/j.ecns.2017.08.007

Graham, C. L., Phillips, S. M., Newman, S. D., & Atz, T. W. (2016). Baccalaureate minority nursing students perceived barriers and facilitators to clinical education practices: An integrative review. *Nursing Education Perspectives, 37*(3), 130–137. https://doi.org/10.1097/01.NEP.0000000000000003 PMID:27405193

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001 PMID:14769454

Gutoskey, E. (2020, June 11). *What's the difference between equity and equality?* Mental Floss. https://www.mentalfloss.com/article/625404/equity-vs-equality-what-is-the-difference

Health Resources and Services Administration. (2019). *2018 national sample survey of registered nurses: Brief summary of results*. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nssrn-summary-report.pdf

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/10.1073/pnas.1516047113 PMID:27044069

Holland, A. E. (2015). The lived experience of teaching about race in cultural nursing education. *Journal of Transcultural Nursing, 26*(1), 92–100. https://doi.org/10.1177/1043659614523995 PMID:24682320

hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom*. Routledge.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687 PMID:16204405

Jean Paul, H. (2019). Equity vs equality: Facilitating equity in the classroom. *International Journal of Research and Scientific Innovation, 6*(11), 216–219. https://www.rsisinternational.org/journals/ijrsi/digital-library/volume-6-issue-11/216-219.pdf

McGibbon, E. A., & Etowa, J. B. (2009). Anti-racist health care practice. Canadian Scholars' Press.

McGibbon, E., Mulaudzi, F. M., Didham, P., Barton, S., & Sochan, A. (2014). Toward decolonizing nursing: The colonization of nursing and strategies for increasing the counter-narrative. *Nursing Inquiry, 21*, 179–191. https://doi.org/10.1111/nin.12042 PMID:23837570

National League for Nursing. (2020). *Nurse educator demographics: Disposition of full-time nurse educators by race-ethnicity, 2017*. http://www.nln.org/docs/default-source/default-document-library/disposition-of-full-time-nurse-educators-by-race-ethnicity-2017.pdf?sfvrsn=0

Puzan, E. (2003). The unbearable whiteness of being (in nursing). *Nursing Inquiry, 10*(3), 193–200. https://doi.org/10.1046/j.1440-1800.2003.00180.x PMID:12940974

Scammell, J. M., & 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 PMID:21839554

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. National Academies Press. doi:10.17226/12875 PMID: 25032386

Tait, R. C., & Chibnall, J. T. (2014). Racial/ethnic disparities in the assessment and treatment of pain: Psychosocial perspectives. *The American Psychologist, 69*(2), 131–141. https://doi.org/10.1037/a0035204 PMID:24547799

Valderama-Wallace, C. P., & Apesoa-Varano, E. C. (2019). "Social justice is a dream": Tensions and contradictions in nursing education. *Public Health Nursing, 36*(5), 735–743. https://doi.org/10.1111/phn.12630 PMID:31168869

Villarruel, A. M., & Broome, M. E. (2020). Beyond the naming: Institutional racism in nursing. *Nursing Outlook, 68*(4), 375–376. https://doi.org/10.1016/j.outlook.2020.06.009 PMID:32896302

Vyas, D. A., Eisenstein, L. G., & Jones, D. S. (2020). Hidden in plain sight — Reconsidering the use of race correction in clinical algorithms. *The New England Journal of Medicine, 383*(9), 874–882. https://doi.org/10.1056/NEJMms2004740 PMID:32853499

Waite, R., & Nardi, D. (2019). Nursing colonialism in America: Implications for nursing leadership. *Journal of Professional Nursing, 35*, 18–25. https://doi.org/10.1016/j.profnurs.2017.12.013 PMID:30709460

Zhong, C. S., Huang, J. T., & Nambudiri, V. E. (2019). Revisiting the history of the "Mongolian spot": The background and implications of a medical term used today. *Pediatric Dermatology, 36*, 755–757. https://doi.org/10.1111/pde.13858 PMID:31141213