ELSEVIER

Inclusive leadership to guide nursing's response to improving health equity

Jacqueline Nikpour[a]*, Ronald L. Hickman[b], Dora Clayton-Jones[c],
Rosa M. Gonzalez-Guarda[d], Marion E. Broome[e]

[a]Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing, Philadelphia, PA
[b]Frances Payne Bolton School of Nursing, Case Western Reserve University, Cleveland, OH
[c]Marquette University College of Nursing, Milwaukee, WI
[d]Duke University School of Nursing, Community Engaged Research Initiative, Duke Clinical Transational Science Institute, Durham, NC
[e]Duke University, Durham NC

ARTICLE INFO

ABSTRACT

The purpose of this manuscript is to examine traditional models of leadership in nursing, and to provide a roadmap and specific recommendations for nurses at all levels to lead our profession through the next decade in achieving health equity. We examine current leadership frameworks in nursing and discuss ways to contemporize these frameworks to more explicitly center the expertise of clinicians and communities from historically marginalized backgrounds. Next, we examine the racial, gender, and able-bodied biases that impact nurses, and call upon nurses to examine and dismantle these biases. We discuss the roles of health systems and academic organizations in developing inclusive leaders, including through community engagement and true service-learning partnerships. Finally, we provide a set of recommendations for all nursing leaders across career stages to embrace inclusivity as they work to improve health equity.

Cite this article: Nikpour, J., Hickman, R.L., Clayton-Jones, D., Gonzalez-Guarda, R.M., & Broome, M.E. (2022, November/December). Inclusive leadership to guide nursing's response to improving health equity. Nurs Outlook, 70(6S1), S10–S19. https://doi.org/10.1016/j.outlook.2022.02.006.

Introduction

The vision laid out in the *Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* (National Academy of Medicine [NAM], 2021) report made it clear that nurses must be at the forefront of changes designed to improve health equity. This vision builds on the Future of Nursing 2010-2020's recommendations — addressing intersecting medical and social needs, providing community-based care to marginalized

populations, and providing high-quality care for everyone. Yet this time, the Future of Nursing 2020-2030 report even more explicitly reaches beyond the brick and mortar of hospitals and health systems. The mandate asks nurses to stretch as leaders, and as a unified profession to address blatant inequities in our healthcare system. Each nurse must find their place in this exciting vision and connect that vision to the work they do daily. We will need all nurses, across all sectors, backgrounds, and career stages to lead and change processes, systems, and structures to improve the health of all people.

Leadership has traditionally been associated with position and power that is often granted based on many years of experience in or outside of nursing. This traditional model will not provide the collective power necessary to achieve the goals of the Future of Nursing 2020-2030 report. This article will examine models of leadership and provide a roadmap for nurses at all levels to lead our profession through the next decade.

Leadership Frameworks for Anti-Racism

To sustain the paradigm shift needed to achieve health equity, foundational frameworks for leadership in nursing are needed. Nurses must understand themselves, and how others and their context has shaped them before they can engage with others as authentic leaders who want to work with and for others. While there are a variety of frameworks available to guide leaders in examining their leadership knowledge, skills, and competencies few of these frameworks emphasize the inner self of the leader and the tremendous influence of culture and context on the development of leaders in nursing (Broome & Marshall, 2020; Im et al., 2018). There will be no cookie-cutter, one-dimensional type of leader who will be able to guide the changes needed to address inequities. Two frameworks, *authentic leadership,* and *cultural humility,* provide some direction for emerging, mid-career and senior leaders, yet these current frameworks are incomplete in their consideration of anti-racism in nursing leadership.

The nursing profession needs the kind of leader who believes that what it will take in a change of this magnitude is a focus on *people* — colleagues in and outside of the profession, clients, and patients. It will be people-centered leaders who are willing to invest in others and engage in crucial conversations to identify what needs to change to achieve health equity. These leaders demonstrate the characteristics of authentic leadership and cultural humility.

Authentic leadership (AL)

To be the strongest leader, it is essential to understand self, one's strengths, areas to develop, how one's leadership has been shaped by others. This deep understanding demands an engagement in self-reflection. AL is a framework that describes how important it is for a leader to know oneself to lead others, as well as to be an engaged follower when appropriate. AL includes four dimensions: self-awareness, balanced processing, an internalized moral perspective, and relational transparency (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). A key principle of authentic leadership is that there is congruency between the leader's thoughts, words, and actions. Studies on the effectiveness of authentic leaders on well-being of

employees at work, patient care quality, and healthy work environments (Wong & Walsh, 2020) have documented improved outcomes and empowerment of others.

The AL theory has been criticized for a lack of awareness of the influence of social context and culture, including organizational culture (Wong & Walsh, 2020). These factors are important in how they influence both the development of the authentic leader as well as the expression of the leader's behaviors and actions. The culture in which an individual is born, nurtured, and educated are crucial to understand, and are a piece of the cultural humility model.

Cultural Humility

One relevant framework for all leaders working in addressing health inequities is the *cultural humility model* (Ackerman-Barger, 2020; Tervalon & Murray-García, 1998). A model containing the major concepts in the framework (Figure 1) elucidates how individuals can develop a person-centered leadership style through continuous self-reflection and development — especially related to diversity, equity, and inclusion (DEI). Cultural humility requires that leaders to be actively engaged in lifelong self-reflection (Foronda, 2020). The culturally humble leader is open to *knowing and valuing* each person they are working with, but especially those who have different perspectives based on their experiences.

The culturally humble leader uses their knowledge to redress *power imbalances* in their relationships and use their power to steward their organization through the difficult journey of opening access to all, while securing and managing resources to help those most in need of support. When these leaders move through their work, they engage with a variety of communities in ways that reflect value and respect for the strengths within the community itself, ground their work in

Figure 1 – The inclusive nurse leader (Broome used with permission - Duke University).

goals set with the community members, regularly seek feedback, and adapt plans based on what the community itself values and believes is useful.

To be most effective, cultural humility should be grounded in antiracism. While cultural humility asks us to commit to self-critique, it does not in and of itself explicate the need for antiracist lens. Antiracism asks us to go beyond being "not racist," evaluate our actions' impact on marginalized communities, and work to dismantle policies and behaviors that, intentionally or unintentionally, cause harm (Murray-García et al., 2021). These frameworks highlight the importance of self-awareness and growth on the development of every leader who is interested in making an impact in the future and helping to address inequities. Such a leader models how to bring a diversity of perspectives alive, who leaves title and position "at the door", and who knows and leverages everyone's strengths toward the outcomes desired by the group.

Culture Biases and Inclusive Leadership

To achieve health equity, nurse leaders must reflect inward and recognize how *culture* impacts how they cultivate organizational culture, make strategic decisions, and lead with an inclusive lens. Although the meaning of the word *culture* has been debated by social scientists for years, Hudelson (2004) views *culture* as "the shared set of values, ideas, concepts, and rules of behavior that allow a social group to function and perpetuate itself" (p.345). Culture is understood to be a dynamic and socially constructed reality that connects individuals. However, individuals who do not share the predominant cultural identity are often socially marginalized (Northouse, 2019). Social scientists call the process of marginalization *othering,* where a dominant group of individuals with a shared cultural identity asserts to being normative, and those who differ based on cultural identity or other social constructs, such as race, gender, or ableness, experience exclusion, oppression, and inequality (Dionne & Turkmen, 2020). Culture and social forces, like othering, can unknowingly influence priority setting and impede attempts to lead and make progress towards equity in health inclusively.

Nurse leaders must be aware of how culture shapes their leadership and, in turn, how their leadership influences culture within their organizations. In the following, we review the literature on how culture and the social constructs of gender, race, ableism, and intersectional identities can affect how nurses lead and effectively advance equity in nursing and health.

Gender Bias

In the female-dominant profession of nursing, there is a gender gap in leadership. Men in nursing have and continue to experience gender prejudice (Heikes, 1991; Porter-O'Grady, 1995; Rajacich, Kane, Williston, & Cameron, 2013). As a result, men comprise a relatively small proportion of the nurse leaders Westphal (2012). noted a relatively insignificant increase in the proportion of men with leadership roles (e.g., executives or frontline supervisors) in healthcare organizations from 1992 to 2008. More recent data from the National League of Nursing, 2020 indicate that men represent only 7% of full-time faculty in academia. The research to explain the cultural, professional, and social forces perpetuating the gender gap in nursing leadership has not been well elucidated.

There is an even stronger lack of representation of transgender and non-conforming (TGNC) individuals in nursing and in leadership positions. A 2014 study of chief nursing officers (CNOs) attitudes toward lesbian, gay, bisexual, and transgender (LGBT) patients and personnel at Magnet hospitals revealed that CNOs demonstrated moderate amounts of homophobia and transphobia, and that those who demonstrated negative attitudes towards LGBT populations were less likely to advocate for them (Klotzbaugh & Spencer, 2014). TGNC patients in particular face exclusion from the health system, including a lack of insurance coverage of gender-affirming care, misgendering by clinicians, and discrimination (Fauer et al., 2020; James et al., 2016). Nurses are well-positioned to provide TGNC-inclusive care, yet receive sporadic, inconsistent education on how to do so (Carabez, Eliason, & Martinson, 2016). Nurse leaders must examine their beliefs and biases on TGNC populations and train others in their organization to practice gender-inclusive care (i.e., asking for patient preferred pronouns, advocating for gender-neutral bathrooms) in order to advance equitable outcomes.

Racial Bias

COVID-19 and the ills of racial injustice catalyzed individuals and institutions to reflect inward on how their policies, practices, and culture contribute to racial and health inequities. Presently, there is heightened awareness of the mechanisms by which racism and white supremacy manifest in nursing and healthcare Following the death of George Floyd, the American Association for Colleges of, 2020 issued a position statement calling for nurse leaders to "eliminate systemic and institutional racism, personal racism, and unconscious bias," and encouraged efforts to make the nursing profession more diverse and inclusive. Unequivocally, racism impacts the quality of nursing and health care and contributes to the widening health disparities among racial and ethnic minorities.

Racism in nursing is visible. The historical and present-day mistreatment of nurses who identify as Black, Indigenous, or a Person of Color (BIPOC) continues to stifle meaningful representation of historically marginalized communities in nursing and leadership

positions. Historically, BIPOC nurses were denied admission to nursing programs and, for those who were able to obtain a nursing education, they were prohibited from becoming members of professional organizations such as the American Nurses Association, and compensated considerably less than their white counterparts. Present-day BIPOC nurses continue to report perceptions of inequity, exclusion, and powerlessness.

Nursing leaders must recognize the complicated history of systemic, institutional, and personal racism experienced by BIPOC nurses. Westernized theories of leadership are fundamentally based on predominately white male viewpoints emphasizing ethnocentrism. However, the challenges of social injustice and racism mandate that nurse leaders apply a lens of cultural and racial relativism to address systemic, institutional, and personal racism in society, healthcare, and nursing. Altman et al. (2021) identify the following core reflection prompts:

1. How do you racially identify? How have others identified you in terms of race?
2. How is your racial identity situated in terms of power and privilege in the context of the United States?
3. How has your racial identity impacted your lived experiences and interactions with others as a nurse?

Ableism

Similar to the social constructs of gender and race, *ableism*, a perspective or attitude that devalues or differentiates through the valuation of an individual's able-bodiedness or normalcy (Campbell, 2008; Dowding, 2008), is a social force embedded in our social and institutional structures that often goes under-recognized by nurse leaders (Fontenot & McMurray, 2020; Procknow, Rocco, & Munn, 2017). In society and within nursing, persons with disabilities (PWDs) experience othering and marginalization and are often falsely perceived as being incapable of being a nurse (Marks & Ailey, 2014; Neal-Boylan & Miller, 2020). This is particularly problematic when many of the patients served by healthcare systems are PWDs.

Self-awareness of ableism is critical for nurses who aspire to be authentic or inclusive leaders. Like sexism and racism, ableism is an oppressive social factor that unfairly labels and hinders PWDs from assuming leadership positions. Therefore, nurse leaders and those who seek to become leaders must reflect on how their belief systems and how ableist perspectives are ingrained in institutional policies and practices that prevent recruitment and successful program completion of disabled students.

To overcome the influences of racism, sexism, transphobia, and ableism, *intersectional identity theory* may help nurses reflect on their implicit biases and lead with a more inclusive lens. According to Van Herk, Smith, and Andrew (2011), intersectionality was first introduced as a theoretical shift from thinking about social constructs such as race, gender, and ableness separately, but rather as interrelated identities associated with systems of oppression. In the United States, nurse leaders are predominantly white women, and are susceptible to othering colleagues and care recipients based on cultural identity. Thus, the intersectionality paradigm can provide nurse leaders a strategy for exploring how social constructs intersect to better understand the perspectives of those who differ by cultural identity. Inclusive nurse leaders must not only acknowledge systemic, structural, and personal sources of biases, but they must take concerted action on how to include the perspectives from those who have been historically excluded or marginalized in the profession and society. In addition to the prompts posed by Altman et al., we recommend that nurse leaders reflect on the following questions

1. To what extent do my research, teaching, care delivery, or leadership teams represent the full spectrum of diversity?
2. In what ways may my own biases influence my decisions and interactions with others?
3. As a leader, how do I model inclusiveness for those around me?
4. Reflect on a leadership experience when you observed or perpetuated implicit bias. How did you or others around you respond? What actions were helpful? What actions further perpetuated bias?

The Role of Health Systems in Developing Inclusive Leaders

Inclusive leaders are individuals who must engage in collaborative learning that engages diverse perspectives to achieve health equity. *Community engagement* is a collaborative learning process where community members, organizations, and leaders work in collaboration with partners and respond to issues or concerns, to promote overall health and well-being (Centers for Disease Control [CDC], 2011; Eder et al., 2018; Pinsoneault, Connors, Jacobs, & Broeckling, 2019). Together, all partners collectively move through an iterative process identifying an issue, developing an action plan to address the issue, carrying out the needed action, and evaluating the response – learning what takes to have meaningful social and health impacts (Eder et al., 2018). Shared decision-making, equal power-sharing, and community involvement are essential aspects of the process of prioritizing issues and identifying solutions (De Weger, Van Vooren, Luijkx, Baan, & Drewes, 2018; Wallerstein, Duran, Oetzel, & Minkler, 2018).

Nurses at all levels, particularly who are part of the community that the organization serves, have a

unique opportunity to bridge the voices of community members and organizations in order to build trust. Such nurses have a unique understanding of the community's health needs, as well as of the positioning of the academic or health system organization within the community. These nurses should be identified and elevated to lead partnerships to advance health equity in the community.

Additionally, the Affordable Care Act's mandate for hospitals to complete a Community Health Needs Assessment (CHNA) provides an opportunity for health systems to engage with communities. An inclusive leader would begin the CHNA by going into the community and amplifying the voices of members by engaging them in conversations about their concerns, experiences, needs, and expectations. Health systems need community engagement teams that partner consistently with community members not only throughout the assessment process, but also by co-designing strategies to address findings and evaluate their impacts. Development of strategic plans where the community had little input and community strengths are not leveraged does not support acceptance of suggested initiatives.

The Role of Academia in Developing Inclusive Leaders

Academic leaders must foster a culture that embraces an inclusive environment of collaborative learning (Haglund, Ortiz, De Los Santos, Garnier-Villareal, & Belknap, 2021; Wallerstein et al., 2018). Three mechanisms by which this culture is created include: (1) awareness of historical context, (2) establishing trust with local communities, and (3) an equity-driven nursing curriculum.

Understanding Historical Context

Schools of Nursing (SONs) must acknowledge the historical context of the university community within which the SON is situated, and the relationship of the university to the local community. For example, during the 1700s to 1800s, universities benefitted financially from the marginalization of Black and Indigenous individuals (Wilder, 2021), and are currently seeking ways to make amends of past wrongs (Schermerhorn, 2021). Academic leaders must educate themselves and their students, faculty, and staff on the specific context of their organization and actively engage in repairing the harm done.

Inclusive leaders engage in collaborative learning that engages diverse perspectives to achieve health equity. *Community engagement* is a collaborative learning process where community members, organizations, and leaders work in collaboration and respond to issues or concerns, to promote overall health and well-being (CDC, 2011; Eder et al., 2018;

Pinsoneault et al., 2019). Together, partners collectively move through an iterative process identifying an issue, developing an action plan to address the issue, carrying out the needed action, and evaluating the response − learning what takes to have meaningful social and health impacts (Eder et al., 2018).

Establishing Trust

Inclusive academic nurse leaders must establish trust, both within their own SON as well as with the community within which they are situated. Establishing trust within the SON requires examining the SON's practices that may foster exclusion and "othering." Selective-admissions processes, for example, may focus on attracting "high-quality" students with top scores and scholastic achievements, while overlooking the potential of students from socioeconomically disadvantaged backgrounds. Many SONs have instituted holistic admissions and diversity pipeline programs with some success (American Association for Colleges of, 2020; Brooks Carthon, Nguyen, Chittams, Park, & Guevara, 2014; Fontenot & McMurray 2020).

Establishing trust with communities requires elevating faculty who have a demonstrated commitment in their research into leading partnerships in *solidarity* with communities. Academic-community partnerships thrive when the SON's historical complicity is acknowledged and responsive actions maintained. This awareness can facilitate dismantling barriers, promoting access to resources, and maintaining collaborative relationships (Williams & Cooper, 2019; Williams, Lawrence, & Davis, 2019). SONs should learn from the successes of minority-serving institutions such as Historically Black Colleges and Universities (HBCUs) in establishing trustworthiness with marginalized communities (Aycock et al., 2021).

Equity-Driven Nursing Curricula

As cited in the Future of Nursing report, Waite and Nardi (2019) argue that professional nursing in the United States originated from colonialism, as early nursing institutions (including Florence Nightingale's training school) excluded BIPOC nurses and as most nurses to date in leadership positions, are white. As a result, they recommend nursing educators engage their students and themselves in self-reflection regarding racism in nursing practice and healthcare. Further, the inclusion of socioeconomic and political determinants of health *across the curricula* − rather than simply in a single public health course at the end of the nursing curriculum − is necessary to prepare nurses to address health inequities, regardless of their postgraduate setting of practice.

Service-learning can help students better understand how socioeconomic determinants influence health and facilitate understanding of communities and individuals as experts in identifying and addressing their needs (Levin et al., 2021). At the same time,

Table 1 – Framework for the Inclusive Nurse Leader.	
Recommendations	Examples
1 Contemporize our theoretical models of inclusive leadership in nursing	• Black nurses at the University of California − Davis Health System built on the tenets of cultural humility (e.g., lifelong commitment to self-evaluation, redressing power imbalances) to develop an anti-racist training designed to equip nurse leaders to deeply reflect on equity as a core component of high-quality patient care (Murray-García et al., 2021). • Waite and Nardi (2019) present a conceptual model displaying the overlapping histories of racism in nursing and America at large, and the outcomes on BIPOC nurses, white-centered nursing curricula, and patient outcomes.
2 All leaders should commit to self-examination of their beliefs, core values and behaviors related to diversity, equity, and inclusion.	• Nurse leaders should invest time and energy in at least three different training opportunities over a 12-month period. These engagements should be selected to enable leaders to understand themselves and their role in changing systemic practices that reinforce traditional approaches to exclusion of others. Training opportunities from Cultural Intelligence (CQ) or the Racial Equity Institute (REI) provide foundational resources, among many other organizations. • The Harvard Implicit Association Test (2022) is a well-regarded resource on self-assessment of bias.
3 Provide support, infrastructure, and training opportunities for community-engaged PhD prepared scholars	• Promote community engagement as a viable, acceptable, and valued approach to scholarship, including research and teaching • Develop infrastructure to eliminate barriers and onerous processes that make community engagement difficult to do. For example, the Betty Irene Moore Fellowship for Nurse Leaders began in 2020 with the goal of funding nursing faculty for equity-centered research. The three-year fellowship places a high priority on diversity among its fellows, and provides ample opportunities to develop skills that promote inclusive excellence to include anti-racism training and mentorship. • Include the impact of community-engaged scholarship as a measure of achievement of criteria towards promotion & tenure • Offer community-engaged opportunities through fellowships, paid student assistantships and course credits • Address recommendations in the *Future of Nursing* report section: "The Need for PhD-Prepared Nurses" (p. 201)
4 Include the role of social, economic, and political determinants in shaping health outcomes within every nursing course in the curriculum	• Introductory courses could include early Black nurse leaders, such as Mary Seacole and Mary Mahoney, as co-founders of modern nursing, as discussed by Waite and Nardi (2019). • Discussions and self-reflections of interpersonal and institutional racism in healthcare should occur across curricula • Service-learning opportunities, in true partnership with communities, should be included as clinical placements • Address recommendations in the *Future of Nursing* report section: "The Need for Integration of Social Determinants of Health and Health Equity into Nursing Education" (p. 198) through curricular review and experiential opportunities for all students
5 Invest in nurturing inclusive leadership for nurses at all stages	• Provide protected time for the added workload that mid-career nurses take on in their organizations • Provide continued financial support for equity-focused programs of research • Offer opportunities for nurses in health systems to engage in community assessment and advancing health equity • Ensure access to senior mentorship through formal channels (e.g., formalized mentorship agreements) • Provide encouragement, support, and credit towards tenure for early and mid-career nurses to assume leadership and service (e.g., on advisory boards) in the communities in which they work.
6 Provide credit for the "hidden" work of mentorship and service that is disproportionately on the shoulders of BIPOC nurse leaders	• Provide special credit allocation for mentorship of students, diversity equity and inclusion work, and community-engaged service with historically marginalized populations • Translate hidden work into a formal leadership role (e.g., Director of Inclusive Mentorship) • Include mentorship of historically marginalized trainees and nurses, DEI work, and community-engaged service to historically marginalized groups as criteria to consider in promotion and tenure guidelines

academia must be mindful that service-learning partnerships can contribute to further colonization of a marginalized population if done improperly and without a truly equal partnership with the community (McKinnon & Fealy, 2011).

Inclusive Leadership Across Career Stages

At the emerging, mid-career, and senior levels of leadership, opportunities for nurses to embrace inclusive leadership exist.

Emerging Leaders

Mentors
For emerging leaders, establishing supportive networks can make the difference in providing a foundation and building confidence. The right mentors, whether formal or informal, are vital for supporting inclusive leadership development. Guided by principles of community engagement, mentors can nurture inclusive leaders by providing a deepened understanding of mutual respect, self-reflexivity, and interpersonal skills and relationships with mentees. Ensuring that SONs have diverse faculty mentors with expertise in community engagement and health equity can support emerging leaders in their development.

Ethnic nursing organizations (ENOs) also serve as collective professional voices for BIPOC nurses to promote initiatives that advance health equity, support excellence in education, and work toward developing partnerships with organizations. ENOs have been instrumental in supporting leadership development and serving as a source of mentoring and support for nurses (Matza, Garon, & Que-Lahoo, 2018). The National Coalition of Ethnic Minority Nurse Associations (NCEMNA) is a "unified force advocating for equity and justice in nursing and health care for ethnic minority populations" and inclusive of all ENOs (NCEMNA, 2020). Partnering with NCEMNA to collaborate on strategies for advancing inclusive leadership promotes development of diverse leaders.

Financial Investments
Supporting inclusive emerging nurse leaders also requires financial investments in their work to advance health equity. In academia, maintenance of new funding from National Institute of Nursing Research and other organizations to support equity-focused research programs is necessary to advance emerging leaders' tenure candidacies. In hospitals and health systems, formalized positions (i.e., Director of Community Engagement), and the creation of community-engagement teams are examples of investments in nursing to promote health equity.

Mid-Career Leaders

Mid-career nurse leaders have skills, expertise, and insight on the legacy of nursing and unmet potential for the future. This stage of development serves as a unique opportunity to serve to bridge "old" and "new" perspectives and propel the nursing workforce forward. Additionally, given demographic trends in the nursing profession, mid-career nurses are more demographically diverse than their more senior counterparts. They have an opportunity to embrace their unique identities and life experiences to define new ways to embody authentic leadership that inspires a more inclusive environment.

Despite this role, the mid-career period is a precarious time. Nurses experience dissatisfaction at work (Coshow, Davis, & Wolosin, 2009) and with scholarly productivity, as their academic workload expands while early-career resources become less accessible (Matthews, Kinser, Warshawsky, Loerzel, & Rice, 2021; Topp, Hershberger, & Bratt, 2017). There are often additional work-life balance demands at mid-career that exacerbate stress and burnout, such as increased caretaking demands for children and aging parents that is evident in the "sandwich generation" that often coincides with mid-career (Canale, Herdklotz, & Wild, 2013; Oulevey Bachmann, Danuser, & Morin, 2015). Burnout and dissatisfaction may be particularly true for BIPOC mid-career nurses who may experience an added "diversity tax," with increased demands on their time to mentor BIPOC students and junior faculty, sit on committees, and contribute to DEI work (Canale et al., 2013; Kinser, 2020; NAM, 2021). Special attention should be paid to the added emotional burden this work has on BIPOC faculty, who often have lived experiences of racism and observe the health consequences this has had in their own families and communities.

To ensure mid-career leaders are retained and have the capacity to translate their experience and expertise into impact, we must invest in resources to support them. This includes provision of protected time for mid-career nurses to serve as leaders, whether it is leading practice changes to promote the inclusion of patients or a scholarly endeavor promoting health equity, and covering the "hidden" administrative, service, and mentoring workload of mid-career nurses, including their community engagement (Kinser, 2020; Matthews et al., 2021). Additional protected time should be considered for mid-career BIPOC nurses who disproportionately invest in DEI activities. Mid-career nurses will also need to be provided support to "re-tool" for inclusive leadership, such as in formal mid-career leadership training. Finally, mid-career faculty should be provided continued mentorship from senior leaders, both in and outside of nursing.

Senior Leaders

Senior nursing leaders are crucial in developing a culture of inclusivity. However, developing such a culture requires leaders to acknowledge that such a culture has not always been in place, and that instances of discrimination, racism, and othering of community members has gone unchecked. Indeed, warranted scrutiny has been placed on the academy for fostering environments that allow for covert and overt discrimination against individuals from historically marginalized backgrounds. Rather, these individuals are discriminated against and excluded, leading to disproportionately high turnover and lack of engagement of those from historically marginalized communities, and ultimately, a less diverse workforce unprepared to serve the needs of diverse populations (Metzger, Dowling, Guinn, & Wilson, 2020; Zarshenas et al., 2017).

Senior leaders must do the work of embracing the Cultural Humility framework, and transparently share that they − as predominantly white, female individuals − do not have all the answers when it comes to inclusive leadership, nor to addressing health inequities. This requires a commitment to accountability and to listening and elevating the voices of organization members who have been targets of discrimination and exclusion.

Recommendations

Recommendations exist for leaders to foster a sense of belonging and culture of inclusivity within their school, healthcare system, or organization Breslin, Nuri-Robins, Ash, and Kirschling (2018). recommended that leaders must "do the work" of becoming culturally proficient and engage a team of individuals who have long championed DEI Metzger et al. (2020). encouraged deans and department chairs to develop skill-building opportunities for faculty, particularly regarding mentoring and engaging BIPOC students and intervening in situations of discrimination. Finally, Villarruel and Broome (2020) emphasize the importance of going beyond calling out racism and forming DEI Committees, and taking concrete actions, creating uncomfortable but necessary discourse, and dismantling traditional policies and procedures that uphold white supremacy and discriminatory practices. In Table 1, we expand upon these recommendations and provide examples of policies and opportunities that nursing organizations can enact to support the development of inclusive leaders.

Conclusion

The Future of Nursing 2020-2030 report's call for nurses to address health equity will set the profession's priorities for the next decade. Charting this path will require inclusive leadership led by those from historically marginalized backgrounds, who have the knowledge and experience to effectively partner with the communities they serve. This will also require active investment in the development of emerging and mid-career leaders to do the same. We have provided initial examples of policies and actions to support these goals that can be incorporated by nursing leaders across settings and organizations.

Authors' Contributions

Jacqueline Nikpour contributed to the conceptualization, initial and subsequent writing, revision, and finalization of the manuscript. Ronald Hickman contributed to the conceptualization, writing, and revising the manuscript. Dora Clayton-Jones contributed to the conceptualization, writing, and revising the manuscript. Rosa Gonazlez-Guarda contributed to the conceptualization, writing, and revising the manuscript. Marion Broome contributed to the conceptualization, writing, and revising the manuscript.

REFERENCES

Ackerman-Barger, P. (2020). Leveraging the power of nurses: Promoting health equity through a framework of cultural humility. Webinar on July 27, 2020. The Future of Nursing, Campaign for Action. www.campaignforaction.org

American Association for Colleges of. (2020). Promising practices in holistic admissions review: Implementation in academic nursing. *Nursing*. https://www.aacnnursing.org/Education-Resources/Tool-Kits/Holistic-Admissions-Tool-Kit.

Aycock, D. M., Alexander, K. A., Cothran, F. A., Randolph, S. D., Young, H. M., & Harden, J. T. (2021). Black nurse scientists and the undeniable role of historically black colleges and universities. *Nursing Outlook*, doi:10.1016/j.outlook.2021.07.001.

Altman, L., Kantrowitz-Gordon, I., Moise, E., Malcolm, K., Vidaković, M., Barrington, W., O'Connor, M. R., & de Castro, A. B. (2021). Addressing Positionality Within Case-Based Learning to Mitigate Systemic Racism in Health Care. *Nurse educator*, 46(5), 284–289, doi:10.1097/NNE.0000000000000937.

Breslin, E. T., Nuri-Robins, K., Ash, J., & Kirschling, J. M. (2018). The changing face of academic nursing: Nurturing diversity, inclusivity, and equity. *Journal of Professional Nursing*, 34(2), 103–109, doi:10.1016/j.profnurs.2017.12.014.

Brooks Carthon, J. M., Nguyen, T.-H., Chittams, J., Park, E., & Guevara, J. (2014). Measuring success: Results from a national survey of recruitment and retention initiatives in the nursing workforce. *Nursing Outlook*, 62(4), 259–267, doi:10.1016/j.outlook.2014.04.006.

Broome, M., & Marshall, E. (2020). *Transformational leadership in nursing: From expert clinician to influential leader* (3rd ed.). Springer Publishing Company.

Campbell, F. K. (2008). Refusing able (ness): A preliminary conversation about ableism. *M/C Journal, 11*(3), 1–9.

Canale, A. M., Herdklotz, C., & Wild, L. (2013). *Mid-career faculty support: The middle years of the academic profession.* Rochester, NY: Faculty Career Development Services, the Wallace Center, Rochester Institute of Technology.

Carabez, R. M., Eliason, M. J., & Martinson, M. (2016). Nurses' knowledge about transgender patient care: A qualitative study. *ANS. Advances in nursing science, 39*(3), 257–271, doi:10.1097/ANS.0000000000000128.

Centers for Disease Control & Prevention (2011). Community Engagement: Definitions and Organizing Concepts from the Literature. Principles for Community Engagement (2nd Ed.) pp. 3–10.

Coshow, S. M., Davis, P., & Wolosin, R. J. (2009). The'big dip': Decrements in RN satisfaction at mid-career. *Nursing Economics, 27*(1), 15.

De Weger, E., Van Vooren, N., Luijkx, K. G., Baan, C. A., & Drewes, H. W. (2018). Achieving successful community engagement: A rapid realist review. *BMC Health Services Research, 18*(1), 285, doi:10.1186/s12913-018-3090-1.

Dionne, K. Y., & Turkmen, F. F. (2020). The politics of pandemic othering: Putting COVID-19 in global and historical context. *International Organization, 74*(S1), E213–E230, doi:10.1017/S0020818320000405.

Dowding, K. (2008). Power, capability and ableness: The fallacy of the vehicle fallacy. *Contemporary Political Theory, 7*(3), 238–258.

Eder, M. M., Evans, E., Funes, M., Hong, H., Reuter, K., Ahmed, S., . . ., Wallerstein, N. (2018). Defining and measuring community engagement and community-engaged research: Clinical and translational science institutional practices. *Progress in Community Health Partnerships: Research, Education, and Action, 12*(2), 145–156, doi:10.1353/cpr.2018.0034.

Fauer, A. J., Manges, K., Stroumsa, D., Sinko, L., Adynski, G. I., Aronowitz, S. V., & Choi, K. R. (2020). Catalyzing a nursing response to healthcare discrimination against transgender and nonbinary individuals. *Journal of Nursing Scholarship, 52*(6), 599–604.

Fontenot, J., & McMurray, P. (2020). Decolonizing entry to practice: Reconceptualizing methods to facilitate diversity in nursing programs. *Teaching and Learning in Nursing, 15*(4), 272–279, doi:10.1016/j.teln.2020.07.002.

Foronda, C. (2020). A theory of cultural humility. *Journal of Transcultural Nursing, 31*(1), 7–12, doi:10.1177/1043659619875184 PMID: 31516091.

Haglund, K., Ortiz, A., De Los Santos, J., Garnier-Villareal, M., & Belknap, R. A. (2021). An engaged community-academic partnership to promote positive youth development. *Journal of Community Engagement Scholarship, 13*(2), 1–10.

Heikes, E. J. (1991). When men are the minority: The case of men in nursing. *The Sociological Quarterly, 32*(3), 389–401.

Hudelson, P. M. (2004). Culture and quality: An anthropological perspective. *International Journal for Quality in Health Care, 16*(5), 345–346, doi:10.1093/intqhc/mzh076.

Im, E. O., Broome, M. E., Inouye, J., Kunaviktikul, W., Oh, E. G., Sakashita, R., . . ., Wang, H. H. (2018). An emerging integrated middle-range theory on women's leadership in nursing. *Journal of Transcultural Nursing, 29*(4), 318–325, doi:10.1177/1043659618760397 PMID: 29478380.

James, S., Herman, J., Rankin, S., Kiesling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 US Transgender Survey*. Washington, DC: National Center for Transgender Equality. Retrieved from https://www. transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

Kinser, P. A. (2020). Thrive, not just survive: The experience of a fellow in the SBM Leadership Institute to enhance opportunities for success of mid-career nurse scientists. *Translational Behavioral Medicine, 10*(4), 912–914.

Klotzbaugh, R., & Spencer, G. (2014). Magnet nurse administrator attitudes and opportunities: Toward improving lesbian, gay, bisexual, or transgender-specific healthcare. *The Journal of Nursing Administration, 44*(9), 481–486.

Levin, M. B., Bowie, J. V., Ragsdale, S. K., Gawad, A. L., Cooper, L. A., & Sharfstein, J. M. (2021). Enhancing community engagement by schools and programs of public health in the United States. *Annual Review of Public Health, 42*, 405–421, doi:10.1146/annurev-publhealth-090419-102324.

Marks, B., & Ailey, S. (2014). White paper on inclusion of students with disabilities in nursing educational programs for the California committee on employment of people with disabilities (CCEPD). Retrieved from https://www.aacnnursing.org/Portals/42/AcademicNursing/Tool%20Kits/Student-Disabilities-White-Paper.pdf

Matthews, E. E., Kinser, P. A., Warshawsky, N., Loerzel, V., & Rice, M. (2021). The perceived reality and environment of the mid-career nurse scientist. *Nursing Outlook, 69*(3), 276–285.

Matza, M. R., Garon, M. B., & Que-Lahoo, J. (2018). Developing minority nurse leaders: The anchor and the rope. *Nursing Forum*, doi:10.1111/nuf.12261 Advance online publication.

Mckinnon, T. H., & Fealy, G. (2011). Core principles for developing global service-learning programs in nursing. *Nursing Education Perspectives, 32*(2), 95–101. https://journals.lww.com/neponline/Fulltext/2011/03000/CORE_PRINCIPLES_for_Developing_Global.8.aspx.

Metzger, M., Dowling, T., Guinn, J., & Wilson, D. T. (2020). Inclusivity in baccalaureate nursing education: A scoping study. *Journal of Professional Nursing, 36*(1), 5–14, doi:10.1016/j.profnurs.2019.06.002.

Murray-García, J., Ngo, V., Marsh, T., Pak, T., Ackerman-Barger, K., & Cavanagh, S. J. (2021). Cultural humility meets antiracism in nurse leader training. *Nurse Leader, 19*(6), 608–615, doi:10.1016/j.mnl.2021.08.017.

National Academies of Sciences, Engineering and Medicine. (2021). *Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. Washington, DC: The National Academies press.

National Coalition of Ethnic Minority Nurse Associations [NCEMNA] (2020). Retrieved from https://aapina.org/national-coalition-of-ethnic-minority-nurse-associations/.

National League of Nursing. (2020). *Faculty Census Suvey (2018-2019)*. Retrieved from https://www.nln.org/nlnNews/newsroom/nursing-education-statistics

Neal-Boylan, L., & Miller, M. (2020). How inclusive are we, really? *Teaching and Learning in Nursing, 15*(4), 237–240, doi:10.1016/j.teln.2020.04.006.

Northouse, P. G. (2019). *Leadership: Theory and practice (Eighth Edition)*. Los Angeles: SAGE Publications.

Oulevey Bachmann, A., Danuser, B., & Morin, D. (2015). Developing a theoretical framework using a nursing perspective to investigate perceived health in the "Sandwich Generation" Group. *Nursing science quarterly, 28*(4), 308–318.

Pinsoneault, L. T., Connors, E. R., Jacobs, E. A., & Broeckling, J. (2019). Go slow to go fast: Successful

engagement strategies for patient-centered, multi-site research, involving academic and community-based organizations. *Journal of General Internal Medicine, 34*(1), 125–131, doi:10.1007/s11606-018-4701-6.

Porter-O'Grady, T. (1995). Reverse discrimination in nursing leadership: Hitting the concrete ceiling. *Nursing Administration Quarterly, 19*(2), 56–62.

Procknow, G., Rocco, T. S., & Munn, S. L. (2017). Dis) able-ing notions of authentic leadership through the lens of critical disability theory. *Advances in Developing Human Resources, 19*(4), 362–377.

Rajacich, D., Kane, D., Williston, C., & Cameron, S. (2013). If they do call you a nurse, it is always a "male nurse": Experiences of men in the nursing profession. *Nursing Forum, 48*(1), 71–80, doi:10.1111/nuf.12008.

Schermerhorn, C. (2021). Colleges confront their links to slavery and wrestle with how to atone for past sins. The Conversation US Incorporated. https://theconversation.com/colleges-confront-their-links-to-slavery-and-wrestle-with-how-to-atone-for-past-sins-152308

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*, 117–125, doi:10.1353/hpu.2010.0233.

Topp, R., Hershberger, P. E., & Bratt, M. (2017). Answering wicked questions: Dealing with opposing truths as a nursing associate professor. *Western Journal of Nursing Research, 39*(6), 733–744.

Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry, 18*(1), 29–39.

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

Waite, R., & Nardi, D. (2019). Nursing colonialism in America: Implications for nursing leadership. *Journal of Professional Nursing, 35*(1), 18–25, doi:10.1016/j.profnurs.2017.12.013.

Wallerstein, N., Duran, B., Oetzel, J., & Minkler, M. (2018). *Community-based participatory research for health: Advancing social and health equity.* Jossey-Bass.

Walumbwa, Avolio, B., Gardner, W., Wernsing, T., & Peterson, S. (2008). Authentic leadership: Development and validation of a theory-based measure. *Journal of Management, 34*(1), 89–126.

Westphal, J. A. (2012). Characteristics of nurse leaders in hospitals in the USA from 1992 to 2008. *Journal of Nursing Management, 20*(7), 928–937, doi:10.1111/j.1365-2834.2012.01403.x.

Williams, D. R., & Cooper, L. A. (2019). Reducing racial inequities in health: Using what we already know to take action. *International Journal of Environmental Research and Public Health, 16*(4), 606, doi:10.3390/ijerph16040606.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health, 40*, 105–125, doi:10.1146/annurev-publhealth-040218-043750.

Wong, C., & Walsh, E. (2020). A scoping review of Authentic Leadership. *Journal of Nursing Management, 28*(1), 1–3.

Zarshenas, L., Sharif, F., Molazem, Z., Khayyer, M., Ebadi, A., & Zare, N. (2017). Professional belonging in nursing students: A qualitative research. *Sadra Medical Journal, 6*(1), 45–56.