JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472
Journal of Holistic Nursing Science

Article journey
Submitted
6/10/2025
Revised
13/12/2025
Accepted
14/12/2025
Online first
4/6/2026

REVIEW ARTICLE

Violations of a shared humanity: A scoping review

Colleen Ann Maykut[1], Yamileth Castano Mora[2], Beatriz Elena Arias Lopez[3], Hanna Ouellette[4], Claire Mallette[5]

Author information
[1] Rankin School of Nursing, Saint Francis Xavier University, Canada
[2] School of Nursing, University of Valle, Colombia
[3] Faculty of Nursing, University of Antioquia, Colombia
[4] PhD candidate, Faculty of Health Sciences School of Nursing, University of Ottawa, Canada
[5] Faculty of Nursing, York University, Canada

cmaykut@stfx.ca

https://doi.org/10.31603/jhns.v13i1.14970

Abstract
Understanding how power can serve to either safeguard or violate humanity lays the groundwork for examining the instances of violation. Nurses must ensure that they prioritize individual's needs through awareness of structural barriers and processes, such as decision-making and resource allocations, to ensure healthcare delivery is equitable. Therefore, the review aimed to investigate what is known from the existing literature regarding violations of a shared humanity by nurses to oppress and dehumanize individuals seeking healthcare. The scoping review adopted Arksey and O'Malley's framework to guide data analysis. Numerous databases and platforms were utilized to explore studies that focus on violations perpetrated by nurses. These included *Biblioteca Virtual en Salud* (BVS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Dialnet, Elsevier, Google Scholar, Medline, ResearchGate, Redalyc, and Scielo. Articles published in English, French, Portuguese, and Spanish between 1972 and 2023 were analyzed. A total of 46 articles from the original 1078 articles were included. The analyses revealed three central themes such as dehumanization, the presence of both unconscious and conscious biases, and medicalizing rationality utilizing a thematic analysis approach to discern patterns. These phenomena emerge as effects of systems of oppression and structures of power, whose primary support and expression lie in persistent symbolic and structural violence. Interest in understanding this phenomenon is evident by 50% of the studies published since 2016. The findings revealed that conscious and unconscious violations have been documented against individuals seeking healthcare. A call to action to wade into this uncomfortable discussion, within all practice domains, must occur to mitigate violations because of the power dynamics between a nurse and patient. Addressing these acts in clinical practice through policy, legal recourse, and professional regulatory associations is mitigating harm towards individuals seeking healthcare. This problem is a global phenomenon (18 countries) in multiple settings.

Keywords: Dehumanization, intersectionality, nurse, oppression, power, violation

Introduction

Intersectionality provides a framework for understanding the multiple influencing factors that culminate in oppression and privilege (Crenshaw, 1989). This framework is critical for promoting equity and liberation by dismantling oppressive systems (Dong & Temple, 2011; Hankivsky & Christoffersen, 2008; Maykut, 2021; Simpson, 2009). The situations of power, privilege, and oppression are unique to each individual and are expressed when in relationship with others **(Figure 1)**. The inner green circle reflects those unique characteristics acquired by birth or life experiences. Situations of inclusion and/or exclusion are manifested by discrimination, noted as the blue circle. Acts of dehumanization as discrimination are perpetuated by the outermost green circle or societal beliefs and values as to who matters and who does not (Simpson, 2009). Therefore, nurses use their power and privilege to inform their thoughts and actions. Nurses have power because of their professional identities, access to resources, including knowledge and finances, to enable them to guide their nursing practice (Firpo, 2021). In contrast, individual seeking healthcare (ISHC) may not have the ability to have a choice, voice, or a sense of belonging, leading to dehumanization as an act of oppression (Crenshaw,

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

1989; Dong & Temple, 2011; Hankivsky & Christoffersen, 2008). This exclusion reflects social injustice perpetuated by those in power over those with less privilege (McGibbon et al., 2014) as an outcome experienced as violations towards ISHC.

For further elaboration, such violations are not only systemic but also individual, as they strip ISHC of their dignity, autonomy, and acknowledgment of their humanity during healthcare interactions (Hankivsky & Christoffersen, 2008). When ISHCs are stripped of autonomy in this manner, it leads to social injustice and an infringement on their humanity as basic human rights (Dong & Temple, 2011). Such infringements arise when power is wielded in ways that silence or marginalize, turning what should be healing experiences into instances of harm. As a result, the way power and privilege are exercised in healthcare influences whether care honors humanity or leads to its infringement. These infringements do not have to be illegal to inflict significant harm; they undermine dignity and trust, revealing how structural inequalities manifest in clinical practice (McGibbon et al., 2014). Privileges are the opportunities for power or unfair advantages an individual acquires, reflecting their unique social identity and location. These privileges are often given and not earned, which begins the oppressive nature of systemic discrimination - who matters and who does not, which is enforced by societal norms (Crenshaw, 1989; Dong & Temple, 2011; Hankivsky & Christoffersen, 2008). Power can act as a catalyst for either dignity or harm, depending on how it is expressed within care relationships.

Figure 1. Intersectionality Wheel (Permission to use granted by the author).

Bias refers to the negative evaluation of one group relative to another (Blair et al., 2011). Conscious bias involves an individual being consciously aware of their evaluation of a group, believing this evaluation to be accurate, and having both the time and motivation to act on it in each situation (Blair et al., 2011). However, unconscious bias operates automatically and often without intentional endorsement or awareness; triggered by situational cues, such as a person's skin color or accent, and subtly influences perception, memory, and behaviour (Blair et al., 2011). These biases, formed through mental shortcuts essential for quick information processing, can lead to harmful outcomes (Storm et al., 2023). Developing from an early age and shaped by culture, values, and experiences, unconscious biases become ingrained habits of the mind, making their impact on decision-making and thought processes challenging to recognize (Persaud, 2019). Bias, both conscious and unconscious, is found in nursing practice, leading to both overt and subtle discriminatory behaviors that perpetuate the violation of an ISHC. Such violation often arises implicitly through established structures and routines that marginalize certain groups unconsciously (Narayan, 2019). The impact of biases among healthcare providers is significant, contributing to disparities experienced by marginalized groups, including racial, ethnic, or religious minorities, as well as those facing discrimination based on sexuality, gender identity, disability, or stigmatized diagnoses. An overemphasis on a person's biography can create a foundation for oppressive behaviors. Within healthcare, the historical subjugation of nursing often manifests as a vertical replication of this context, where nurses displace their own institutional oppression onto care.

Registered nurses have inherent power and privileges bestowed on them due to their credentials, their work experience, government sanctions, and the nature of the relationship with ISHC (Jenkins et al., 2024; Van Herk et al., 2011). Individuals situated within privileged groups often remain unaware of the historical and structural forces shaping their assumptions and actions (Tang & Browne, 2009). In nursing, a lack of awareness regarding these dynamics can lead practitioners to unintentionally project dominant societal biases onto marginalized patients, further perpetuating healthcare exclusion (Van Herk et al., 2011). Developing this awareness is essential, as “nurses need to take personal initiative to further explore issues of power, privilege, and oppression within their practice and the profession… [and] have a… personal awareness of the privilege afforded to the dominant biomedical model and the power afforded to their role as nurses” (Van Herk et al., 2011). However, focusing on patient vulnerability can distract from the actual perpetrators of healthcare violations. Violations are not passive occurrences; they are concrete actions executed by individuals and institutions that wield power to marginalize, exclude, or oppress. Shifting the focus back to these structural agents—including nurses, policies, and systemic practices—allows to see beyond patient suffering and identify who is responsible for either protecting or degrading human dignity.

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

The above discussion of power, bias, identity, and privilege reveals how structural factors influence whether care supports or undermines the dignity of ISHC attention which is a basic human right. To advance beyond theoretical discussions, it is vital to demonstrate how these dynamics play out in real situations. The following examples from Canada, Colombia, and the international sphere illustrate how power dynamics and systemic disparities become evident during healthcare interactions. By placing these instances, the analysis indicates that these violations are not merely isolated events, but rather manifestations of overarching patterns of oppression and dehumanization. There have been many reported incidents of nurses who have committed unlawful acts resulting in neglect and even murder. This section intends to provide an overview of the current state of systemic discrimination in a few selected countries from both a popular media perspective and systemic discrimination research studies. In Canada, Mr. S and Ms. E were Indigenous Canadians who died due to neglect and systemic discrimination (Geary, 2017; Nerestant, 2021). Mr. S was admitted for a simple urinary tract infection to a busy emergency room (ER). The patient was disregarded by nurses for over 34 hours and died without anyone interacting with him. Then, Ms. E live-streamed the inhumane treatment by nurses with racist slurs and neglect by nurses, which led to her death. Although these are two publicized deaths which should never have occurred and were preventable, they are not isolated incidents. References acknowledge many unreported and unpublicized incidents of violation and dehumanization acts perpetrated by healthcare personnel, including nurses across Canada (Comeau et al., 2023; McLane et al., 2022; Turpel-Lafond, 2020). The nurses in both of the above situations were not disciplined for their actions. Despite Canada's reputation for universal and accessible healthcare, Indigenous Peoples continue to experience profound inequities. A UN Special Rapporteur described the gap between services available on reserve and those available to non-Indigenous citizens as the most severe human rights violations present in Canada (United Nations, 2026). However, with increasing incidents of racism and marginalization of individuals/communities both The Government of Canada (2021), the Canadian Nurses Association (CNA) (2024a), and The Canadian Federation of Nurses Union (CFNU) have provided statements to facilitate and uphold equity, diversity and inclusion with respect to healthcare.

Nursing has been intertwined with these systems in Canada through its historical participation in Indian hospitals, residential schools, child apprehension, and forced sterilization, contributing to long-standing mistrust and inequitable care (Symenuk et al., 2020). The CNA has committed to educational initiatives, summits, and working groups designed to equip practicing nurses with the knowledge required to uphold social justice (Canadian Nurses Association, 2024b). Through these efforts, nurses are encouraged to reflect on their professional role regarding both the historical and ongoing trauma experienced by many Indigenous Peoples. Of note, the latest version of the CNA Code of Ethics (2025) has been updated to highlight previous calls to action focusing on reconciliation with Indigenous Peoples and an anti-racism stance to reflect the importance of social justice. This newest version offers individual nurses' guidance on examining their explicit and implicit biases and strategies to enhance advocacy for those who may not have agency. Acknowledging ongoing harms, the CFNU (2025) issued a national apology on June 3, 2025, recognizing nursing's involvement in colonial practices and affirming racism's continued threat to Indigenous patient safety. The apology underscored the profession's responsibility to use its influence to advance reconciliation and ensure safe, inclusive healthcare for Indigenous Peoples.

The legacy of colonialism in healthcare—which manifests as institutional and structural oppression rooted in a global history of power and discrimination—has been deeply scrutinized and correlated with poor health outcomes (Fleming & Spicer, 2014; Jenkins et al., 2024). Vulnerability has replaced marginalization when identifying individuals/communities at risk for dehumanization (Canadian Nurses Association, 2024b; Symenuk et al., 2020). People are not vulnerable, but instead they are violated in this case by nursing professionals who may be supported and/or constrained by the politics of the health care system through actions of conscious and unconscious biases (Symenuk et al., 2020). In this way, there is an acknowledgement that some behaviors by nurses maybe conscious while others are subconscious; either/or an action has occurred which dehumanized ISHC. Power differentials continuously shift in relationships due to individual differences (Atwood & Scholtz, 2005; Collins, 2000; Sukhera et al., 2023). Whether an individual has more financial, educational, or decision-making resources and authority, an imbalance occurs unless critical steps are taken to mitigate the inequity of voice and power. This power differential also exists in professional relationships, including healthcare. Power differentials that occur in healthcare settings among personnel, particularly physicians and nurses, have been studied in various settings and from a social science lens (Ammann et al., 2021; Bochatay et al., 2021; Campbell-Heider & Pollock, 1987; Engel et al., 2017; Essex et al., 2023). The substantive theoretical and editorial literature attending on power differentials reveals a dual outcome for the nurse and an ISHC; positively (McMillan et al., 2013) and also as inferior outcome (Baptista et al., 2018; Joseph-Williams et al., 2014; Thirsk et al., 2022). The power differential in caring relationships has been a phenomenon of a recent study in nursing, focusing on how

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

scientific knowledge, hospital rules and routines are instruments of power that violate the individual's identity, and utilize them against patients (Baptista et al., 2018). The connection between power and violation is essential, as the use of power in caregiving relationships not only influences professional authority but can also compromise the dignity and humanity of those ISHC. The relationship between an ISHC and a nurse may establish a milieu for violation and manifested as acts of oppression due to the intimacy of physical care, the time spent together, and the inherent power bestowed on the nurse. Viewed as a continuum, oppression manifests in actions ranging from the exclusion of the ISHC's voice to severe acts of dehumanization, culminating in death as the ultimate denial of health as a fundamental human right (World Health Organization, 2024).

Nurses must recognize structural barriers and organizational processes—such as resource allocation and decision-making—to ensure that care is prioritized according to individual needs and delivered equitably. Failure to do so may be a result of not understanding systemic pressures and/or a hegemonic approach reflective of nurse knows best. This second influence, hegemony, perpetuates health inequities for individuals resulting in discrimination which may lead to reluctance in seeking healthcare and worse outcomes presenting as complications, higher rates of morbidities and early deaths (McLane et al., 2022; Tang & Browne, 2008). Postcolonial theory helps explain these disparities by highlighting how colonial power structures and the dominance of the Western biomedical model continue to shape healthcare practices (Anderson et al., 2003).

An additional example can be drawn from Colombia. A media wave was unleashed in 2022 when several cases of sexual abuse perpetrated by a male nursing assistant in a psychiatric unit in Bogotá (Infobae, 2022). The nurse took advantage of the vulnerability of the patients, who were not only sedated but also many were minors. Co-workers reported 11 unethical and illegal behaviors to hospital administrators. However, administrators cited a lack of staffing as the rationale for not investigating or disciplining the individual (Infobae, 2022). The situation of direct violence perpetrated by a nursing assistant is part of many cases of sexual abuse. A distinct pattern can be identified in which male nurses perpetrate violence against women and other vulnerable individuals. This behavior reflects deep-rooted patriarchal structures that manifest as a series of oppressive actions, ultimately normalizing misogyny and sexism within professional care relationships. Unfortunately, available evidence does not allow for the precise documentation of the various forms of violence or abuse of power recorded by nursing ethics tribunals and professional organizations in Colombia. This limitation exists because no studies providing such comprehensive data were identified in the current literature. Nonetheless, Colombian healthcare settings suggests that institutional and psychological violence, information withholding, and documentation deficiencies represent significant ethical concerns in nursing practice. Moreover, systemic and institutional factors exacerbate these issues including limited access to resources, time constraints, high patient loads, and supply shortages. At the individual level, high nurse-to-patient ratios, a lack of patient autonomy, and total dependence on medical staff create an adverse environment. Consequently, a patriarchal and authoritarian healthcare model remains prevalent (Jojoa-Tobar et al., 2019; Parra et al., 2019). In Colombia, nursing regulatory and ethical bodies maintain a deontological framework intended to ensure that the profession is practiced with dignity, respect, and responsibility. For instance, the National Ethics Tribunal, the Collegial Nursing Organization, and the Colombian Association of Nursing Schools. However, no public statements explicitly condemning acts of violence by nurses. Official documents mostly report cases of negligence, clinical errors, omissions, or falsification of records, which are treated as technical failures rather than as abuse of power or forms of violence.

Meanwhile in a global context, acts of discrimination based on ethnicity, sexual identity, age, neurological and physical abilities, and gender are increasing as violations of basic human rights (World Justice Project, 2023). Many governments and associations have policies and laws to mitigate discriminatory acts. However, there continue to be preventable deaths who seek healthcare. Statistics and news outlets continue to reveal the daily struggles and even deaths due to their unique social identity (Australian Institute of Health and Welfare [AIHW], 2022; Burke, 2020; Hart, 2021; Murray, 2022; O'Donoghue et al., 2023). Therefore, the purpose of this scoping review was to examine the literature to answer the question, what is known from the existing literature about acts of violations perpetuated by a nurse towards ISHC? This paper draws on the literature to examine how nurses' power, identity, and the vulnerability of ISHC shape whether care is delivered in ways that humanize or dehumanize. The review utilized an intersectionality lens to inform perspective and analysis on acts of violations as examined the literature. Understanding how power can serve to either safeguard or violate humanity lays the groundwork for examining the instances of violation discussed in this review. The findings revealed a global trend of violations by nurses against ISHC in various settings. This review provides critical evidence for future research studies, assesses and strengthens current healthcare policies, and informs nursing curricula. Finally, the findings are integrated into the discussion, which addresses descriptive results, thematic insights, limitations, and conclusions. Through this structure, the paper demonstrates that nurses' obligations and commitments

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

to humanize care are not merely abstract ideals; instead, they are influenced by multiple factors that can also contribute to oppression and dehumanization.

Method

A scoping review was chosen as the approach for a variety of reasons, with the overall intent to explore the conceptual underpinnings, influencing factors, and outcomes that are part of this phenomenon. The review also intended to ensure the inclusion of many different study designs. Secondly, to identify research gaps for future studies, specifically to guide curricular decisions for nursing education. The authors followed Arksey and O'Malley's (2005) five stages for conducting the scoping review as an iterative and reflective process as a group **(Figure 2)**. The phenomenon of violation by nurses towards those they are called to care for has not been thoroughly examined by nurse researchers. Therefore, analyzing what currently exists is necessary to begin the conversation to address these acts of dehumanization. The following central research question to guide our review was: "What is known from the existing literature about acts of violations perpetuated by a nurse towards an individual seeking healthcare?" A discussion amongst group members helped to identify the most relevant electronic data bases, key words, and inclusion and exclusion criteria. The first author created the search table/strategies to screen relevant studies in the electronic databases. The following databases were utilized to obtain relevant studies: BVS, CINAHL, Dialnet, Elsevier, Google Scholar, Medline, ResearchGate, Redalyc, and Scielo. Grey literature was excluded as the main focus of this review was to explore published and peer-reviewed literature; however, published reports and news media can be found in the background section.

A list of inclusion and exclusion criteria were developed to guide this review. Peer-reviewed articles published over five decades (1972 to 2024), written in four languages (English, French, Portuguese, and Spanish), reflecting research examining acts of violation towards individuals seeking healthcare, and a focus on either undergraduate nursing students or regulated nurses were included. Exclusion criteria were languages other than those identified above, as none of the researchers would be able to translate and/or interpret. Those articles which were editorial, theoretical and/or nursing education interventions were also excluded because they did not include primary data or was not the primary focus on this project. Covidence was chosen as the review platform due to familiarity and ease for the authors. Covidence is a software program that enables researchers to manage the workflow of critical analysis reviews, such as systematic, scoping reviews or other evidence syntheses. The first author imported all 1,078 identified articles into Covidence, a platform designed to streamline screening, data extraction, and synthesis. Following this, a pilot test was conducted using 10% of the papers to ensure the consistent application of inclusion and exclusion criteria, with the findings subsequently presented to the research team. There were no disagreements or concerns and the criteria for inclusion and exclusion were accepted without any modifications. Sixty-six duplicate papers were removed. The authors were divided into two groups depending on their expertise in languages chosen: English/French and Portuguese/Spanish to review the 1,012 abstracts. The first author reviewed all the English articles and was a consultant for any discrepancies with the other languages to ensure mutual agreement. This step of the review process excluded 813 papers based on the predefined inclusion and exclusion criteria resulting in a total of 199 studies which progressed to the full-text review phase. One article was not available through any of our institutions, nor when requested through colleagues at other institutions, which left 198 articles to be included. Following a subsequent review process, the research team excluded 152 articles for various reasons, resulting in a final analysis of 46 articles **(Figure 3)**.

Figure 2. The review processes.

Within Covidence a data template was created to extract general (e.g., title of the paper, author(s), year of publication, discipline, country, the aim of the research, study design, and settings) and specific information (e.g., main

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

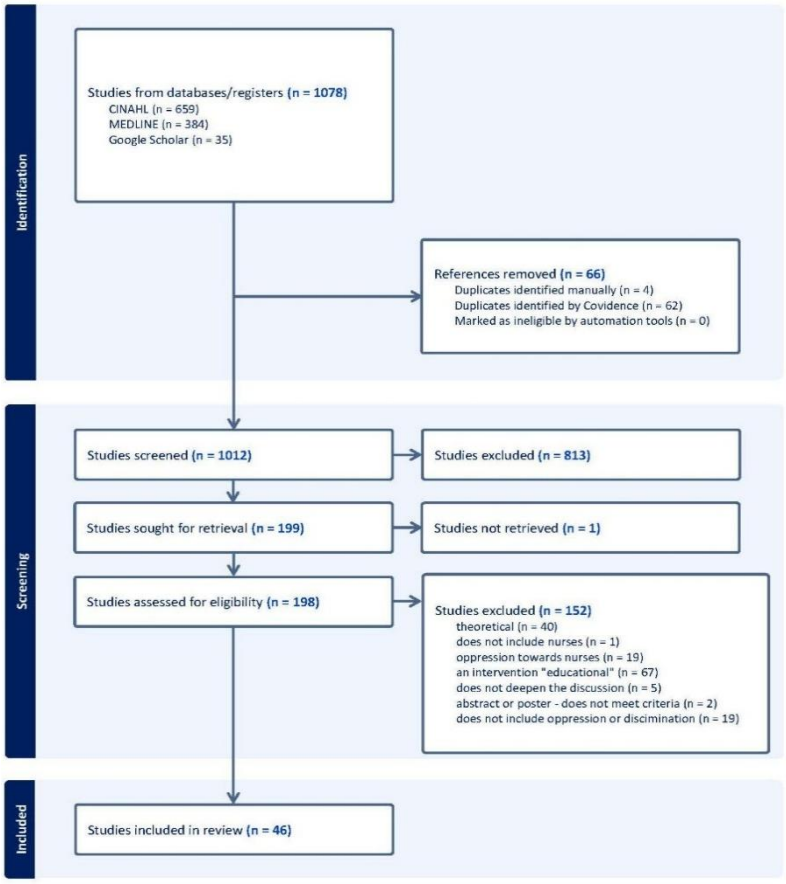

Figure 3. Study selection process using PRISMA version 6.

findings) of the selected studies. Other relevant information, such as direct quotes from participants, was also retrieved to enhance the data analysis. In this final step, the review utilized the previously mentioned intersectionality wheel (Simpson, 2009) as a framework to organize and summarize the data to enhance the understanding of the phenomenon. Data was originally collated with an influencing factor that culminates in oppression and privilege structure (e.g., ageism, homophobia and racism) and then summarized. Themes were generated from this summary by observing for patterns of key words and behaviors which correlated with violations. Finally, the results were reported in a narrative way. Thorne (2025) suggests that utilizing a conceptual schema elevates the collation and summarization of data, revealing deeper insights among the elements. As researchers engage in critical discourse, this framework allows them to move beyond mere labeling and enter a process of true interpretation. Over several months, our research group engaged in an iterative process of data immersion and collaborative dialogue. By repeatedly reviewing the dataset and discussing our unique perspectives, the themes emerged organically, ultimately yielding a novel understanding of the data. This thematic analysis rendered visible five decades of literature on healthcare violations, contextualizing the findings to advance knowledge regarding the vital importance of a shared humanity between ISHCs and nurses. Of note, a formal review protocol and registration do not currently exist for this study.

Results

The review included 46 peer-reviewed studies met the criteria. No additional records were retrieved from other sources. The selected studies are found in a window from 1995 to 2022, occupying nearly thirty years of inquiry. Particularly, 50% of the studies have been published since 2016, indicating an increase in interest in this topic over the last decade, with uninterrupted publication since 2009. These findings corroborate that, as a topic, the phenomenon has been positioned in an incipient and emerging way in recent years for nursing **(Table 1)**. There were 19 studies (41%) originating from Spain (9 studies) and the United Kingdom (4 studies), followed by Hungary, Belgium, Finland, Greece, Ireland and Sweden with one study each. A similar situation is noted in the American continents, with a total of 18 studies (39%). The majority were written by American authors (10 studies), followed by Canada (4 studies), with only 4 studies from South American countries (Brazil 1 study; Chile 1 study; and Colombia 2 studies).

The Asian continent provides four studies (9%) carried out in China, India, Jordan, and five studies (11%) originate specifically from Australia. In comparison, the Asian continent provides four studies (9%), carried out in China, India, Jordan, and Turkey. No studies conducted in Africa were found. The scoping review affirms that 70% of the retrieved studies originate from countries in the Global North. This concentration indicates that while the topic has recently been integrated into nursing research agendas, its global distribution remains uneven, with significantly less resonance within the nursing academies of the Global South. The settings where the studies have been carried out are primarily acute hospital settings (39%), community settings (13%), and a variety of areas, including educational/training spaces, groups and collectives, homes, organizations, and documentary archives, among others (37%). However, in 11% of the studies, it was not possible to identify the research setting. Regulated nurses, as well as nursing students and assistants, were the focus of the studies. ISHC, primarily included those individuals who identified as immigrants and/or members of the

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

LGBTIQ2S+ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Two-Spirit) population have been violated by nurses through their actions or inactions. Some studies are documentary-type, whose primary source were academic databases. The most significant number of studies (11 studies; 24%) reported on violations based on disease, including but not limited to Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and mental health challenges. Eight articles (17%) focused on individuals identifying on the LGBTQ2S+ spectrum, with violations reflecting actions and language of homophobia and transphobia. The third subset focused on racism (7 studies; 15%) and ageism (6 studies; 13%). Classism and sexism had a total of five articles each (22%). Finally, the last grouping included two studies which focused on ableism and opioid users, as well as two additional ones, for which it was difficult to clearly identify the type of violation as defined by Simpson (2009).

A breakdown of countries with their specific discrimination were reported. Ageism as a focus was found in three Australian articles, and one each from Brazil, Jordan and the United Kingdom. With respect to ableism there was only one article from Greece. The United States of America (USA) had three articles focusing on classism, with one article from China and Colombia. Ethnocentrism and Racism were grouped together with two articles from Spain, and one each from Colombia, Turkey and the United Kingdom. Homophobia and Transphobia were also combined resulting in nine articles: three from Spain and the USA, while one article each from Canada and Chile. Violations grounded in sexism included articles from Canada, Colombia, Spain, Sweden and the USA. The largest group focused on violations towards ISHC who had mental health challenges, substance abuse disorders, living with HIV/AIDS, or other diseases and accounted for 13 articles: three from the USA, two from Australia and Spain respectively, and one each from of Canada, Chile, Finland, India, Ireland, and the United Kingdom. There was one additional article which was not specific with respect to an intersectionality focus and originated in Belgium and focused on exclusion of patient participation.

The authors identified three themes from the included studies as follows dehumanization of the individual, contributors of bias in the nursing profession as a group, and medicalizing rationality as influenced by systems and society. To help frame and label the themes, this study drew upon a previous systematic review by Storm et al. (2023). In their review of the literature on unconscious bias, they concluded that bias operates across distinct dimensions, spanning the individual, group, and macro-systemic or societal levels. A detailed description of the findings for each individual theme is presented below.

Dehumanization of the Individual

Roach (2002) asserts that nurses must engage in relationships that actively promote human freedom, authentic connection, and an acknowledgment of each individual's uniqueness. Within this framework, being relational requires a deep awareness of the complexities of reality, a commitment to reasonableness that fosters open-mindedness, and an ethical imperative to ground language and action in our shared humanity. Violations reflect a professional stance where nurses did not embody the above criterion through coercion or dismissiveness on the autonomy of the ISHC. Findings noted fear, disgust, alienation, and disregard by nurses towards individuals' physical bodies, particularly, as living with aging (Koch & Webb, 1996; Parker et al., 2021; Rababa et al., 2020; Robinson & Cubit, 2005; Xiao et al., 2013), with obesity (Shea & Gagnon, 2015; Waller et al., 2012), with physical challenges (Matziou et al., 2009), and intimate partner violence (Moore et al., 1998; Sundborg et al., 2017; Varcoe, 2001). With respect to aging, Xiao et al. (2013) noted nursing students felt that working with older individuals was less professionally stimulating and did not provide an opportunity to validate and improve their psychomotor skills. In general, nurses felt that older individuals were more time-consuming, had little to teach/share, and therefore had less added value for society (Koch & Webb, 1996; Parker et al., 2021; Robinson & Cubit, 2005; Xiao et al., 2013). This objectification of individuals was also noted in the articles focusing on people living with obesity. Nurses believed individuals who were obese were less clean, required extra physical care, and were viewed as a drain on healthcare resources (Shea & Gagnon, 2015; Waller et al., 2012). Many nurses believed that women who experienced intimate partner violence engaged in poor decision-making and brought the abuse upon themselves. Furthermore, they often viewed such violence as an expected outcome within specific socioeconomic and ethnic contexts, particularly poverty (Moore et al., 1998; Sundborg et al., 2017; Varcoe, 2001).

Nurses experienced ethical conflicts when caring for ISHC who used psychoactive substances. This conflict arose because of the ISHC not being allowed to participate in the deliberation and consensus necessary for decision-making (González, 2012). This dehumanizing stance, manifested as violations, was also reflected in articles focusing on communicable diseases such as HIV/AIDS and hepatitis. Those ISHC who acquired hepatitis through intravenous drug use were ostracized, while those who obtained the disease from a blood transfusion received compassionate care (Frazer et al., 2011). Steele and Melby (1995) discovered that nurses touched less and also refused to care for individuals with HIV/AIDS. Sexism and ageism were noted during the triaging process towards women experiencing cardiac events

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

(Arsianian-Engoren, 2000). This dilemma is similar to the care of women who have abortions. When faced with induced abortions, nurses distanced themselves from the women with attitudes of rejection but approached women who had had spontaneous abortions with compassion (Alonso-Muñiz & Arias-Lopez, 2022).

Table 1. Study findings.

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
1	Alonso-Muñiz & Arias-López, 2022	Colombia	What is known about nursing care for those having abortions?	Literature Review with panoramic review in the Scielo, VHL, PubMed and Redalyc databases, with a search window from 2008 to 2020, in Spanish, English and Portuguese languages resulting in 33 articles	Sexism (discrimination based on gender; male being the norm)
2	Arsianian-Engoren, 2000	USA	To examine the triage decisions made by Emergency Department (ED) nurses for persons with symptoms suggestive of myocardial infarction (MI)	Qualitative study, focus groups of 12 ER nurses in two urban and two sub-urban hospitals	Sexism (discrimination based on gender; male being the norm)
3	Cano & Sánchez, 2018.	Chile	To examine the perception of nurses concerning the care given to people living with HIV in a tertiary health care hospital	Qualitative study, focus groups with a semiotic analysis of the discourse with Seven RNs in acute care setting	Homophobia (prejudice against individuals who are LGBTQ2+)
4	Carabez & Scott 2016	USA	Exploring nurses' knowledge and understanding of medical advance directives, medical power of attorney and other legal documents for lesbian, gay, bisexual and transgender	Mixed methods study, using the Health Care Equality Index (2007) with 268 RNs in an acute care facility	Homophobia (prejudice against individuals who are LGBTQ2+)
5	Cassata & Dallas, 2005	USA	Perceptions of challenges and opportunities of low-income childbearing adolescents	Qualitative study, exploratory descriptive study using focus groups with 24 RNs	Classism (prejudice based on social place in society)
6	Castillo Parra et al., 2018	Chile	To find about the perception of nurses about care to people with HIV	Qualitative study with a semiotic analysis of the discourse of seven nurses in an Acute Care Hospital	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
7	Cioffi, 2005	UK	To describe nurses' experiences of caring for diverse adult patients	Qualitative study, sample of 10 RNs on medical and surgical units of an acute care hospital (predominantly consisting of Arabic and Asian patients)	Ethnocentrism (discrimination based on White as the norm)
8	Coelho et al., 2016	Brasil	To understand the ideological base present in the practices of nurses working in health education with adolescents	Qualitative study used creativity and sensitivity dynamics (dialogue - theoretical framework of French Discourse Analysis) with 15 Family Health Strategy RNs in a suburban setting	Ageism (prejudice based on age of patient)
9	Frazer et al., 2011	Ireland	To measure attitudes of primary care nurses towards caring for people with hepatitis C	Quantitative study, cross-sectional survey of 560 nurses working in one health board region in the Republic of Ireland	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health)
10	Gabrielson, 2011	USA	To describe the roles that life experiences, social ties, and expectations for aging play in their decision to live in an LGBT continuous-care setting	Qualitative study with embedded narratives of 10 interconnected older lesbians (>55 years)	Homophobia (prejudice against individuals who are LGBTQ2+)
11	García-Acosta et al., 2020	Spain	To evaluate the explicit prejudices/transphobia of health students and professionals and compare them with the general population in Tenerife	Quantitative study with 602 participants utilizing the genderism and transphobia scale and negative attitude towards trans* people scale	Transphobia (prejudice for individuals who identify as transgender)
12	García-Acosta et al., 2019	Spain	To explore the difficulties for health care perceived by trans* people and by the professionals who assist them	Literature review of multiple databases with a result of 34 articles	Transphobia (prejudice for individuals who identify as transgender)
13	Gil Estevan & Solano-Ruiz, 2017a	Spain	Examine the experiences and perceptions of nurses in providing care and health promotion	Qualitative study, phenomenological of 22 RNs with semi-structure and focus groups in the Department of Health Elda	Racism (discrimination based on ethnicity)

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
14	Gil Estevan & Solano-Ruiz, 2017b	Spain	To understand the assumptions of RNs towards mothers who identify as Gypsy.	Qualitative study with phenomenological trajectory. A focus group with seven RNs in primary health care	Racism (discrimination based on ethnicity)
15	González, 2012	Spain	To know the tools used by nurses to deal with ethical conflicts arising from drug dependent	Qualitative study with focus groups of 7 RNs in a hospital detoxification unit and 12 RNs focused on primary care	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
16	Haghiri-Vijeh, 2022	Canada	Exploring the experiences of LGBTQIA+ migrants who receive care from nurses and healthcare professionals	Qualitative study, semi-structured 16 individual interviews with LGBTQIA+ migrants who received care	Homophobia (prejudice against individuals who are LGBTQ2+)
17	Ihalainen-Tamlander et al., 2016	Finland	To describe nurses' attitudes towards people with mental illness and examine factors associated with their attitudes in primary care center	Quantitative study with 264 nurses in 15 primary care health centers in 2 Finnish cities	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
18	Jacq et al., 2021	USA	Exploring attitudes of RNs and MHTs of stereotyping beliefs about devaluation and discrimination of people with mental illness	Quantitative study with 146 RNs and Mental Health Technicians (MHTs) from a 270-bed psychiatric hospital	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
19	Kantrowitz-Gordon et al., 2022	USA	To explore the stigma of perinatal nurses toward OUD and NOWS during the postpartum period.	Mixed method study with 89 nurses caring for mothers and newborns exposed to opioids in a large urban hospital in the Pacific Northwest United States	Discrimination against disease (opioid use disorder)
20	Karatay et al., 2016	Turkey	To explore Turkish nursing students' perceptions of providing care to patients different from themselves	Qualitative study with 21 students in the second year of a 4-year nursing program. Research questions were based on Campinha-Bacote's model.	Racism (discrimination based on ethnicity)

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
21	Klotzbaugh & Spencer, 2014	USA	To explore magnet hospital chief nursing officers (CNO's) attitudes toward gays and lesbians and the impact that these attitudes have on providing advocacy for lesbian, gay, bisexual, or trans gender (LGBT) patients and staff	Quantitative study with 115 CNOs from magnet organizations responses from The Modern Homonegativity Scale	Homophobia (prejudice against individuals who are LGBTQ2+)
22	Koch & Webb, 1996	UK	To listen to the voices of older patients as they describe their experiences of being a patient in a care	Qualitative study with 14 RNs in a 1000-bed hospital	Ageism (prejudice based on age of patient)
23	Lovi & Barr, 2009	Australia	To describe the assumptions of RNs towards clients struggling with substance abuse	Qualitative study with 6 RNs working in an alcohol and drug unit in South East Queensland	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
24	Malfait et al., 2017	Belgium	To determine if nurses' demographic characteristics influence their willingness to engage in patient participation	Quantitative study with 997 RNs in 22 general hospitals and 3 university hospitals	Other: Exclusion of collaboration
25	Marlow et al., 2015	USA	To provide an opportunity for formerly incarcerated adults and graduate nursing students to participate in a conversation about ethical knowing	Qualitative study - dialectic conversation with 30 graduate (MN) nursing students and 3 formerly incarcerated individuals; followed by focus groups	Classism (prejudice based on social place in society)
26	Matziou et al., 2009	Greece	To investigate the attitudes of pediatric nurses and nursing students towards disabled children	Quantitative study with 228 first-year nursing students, 90 post-diploma nurses and 123 nurse professionals	Ableism (prejudice based on deficits - cognitive, physical)
27	Merryfeather & Bruce, 2014	Canada	To increase awareness in supporting care of those who do not fit comfortably within culturally defined parameters of male and female	Literature review and qualitative study with embedded narratives of 3 clinical patients	Homophobia (prejudice against individuals who are LGBTQ2+)

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
28	Ming et al., 2019	China	To analyze patients' complaints filed against nurses from a nursing ethics perspective	Chart review analysis with 1214 complaints that were used to compare and interpret the frequencies and characteristics of complaints against nurses	Classism (prejudice based on social place in society)
29	Moore et al., 1998	USA	To compare the education, attitudes, and practices related to domestic violence of perinatal nurses	Quantitative study by using survey from three types of practice sites of 275 nurses in perinatal practice (87 public health, 71 hospital, and 117 private office nurses)	Classism (prejudice based on social place in society)
30	Nagothu et al., 2018	India	Examination of whether nursing students' stigmatizing attitudes were related to the number of years at their educational institution	Mixed methods study with survey and focus groups of 310 BScN students and 119 ANM students	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
31	Parker et al., 2021	Australia	To explore the knowledge and misconceptions of ageing among first year undergraduate nursing students and aged care staff	Mixed methods study with 15 first year nursing students and 15 aged care staff in three different RACFs (residential aged care facilities)	Ageism (prejudice based on age of the patient)
32	Rababa et al., 2020	Jordan	To examine how the sociodemographic and professional characteristics of nurses in Jordan correlate with their levels of knowledge, attitudes, and ageism toward older adults	Mixed methods study with 317 Jordanian nurses (at a public hospital and a university hospital)	Ageism (prejudice based on age of patient)
33	Reed & Fitzgerald, 2005	Australia	To investigate nurses' attitudes to caring for people with mental illness, the issues that impact ability to provide care	Qualitative study with 10 nurses from two wards in a rural hospital	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
34	Robinson & Cubit, 2005	Australia	To investigate what is known about how student nurses deal with 'old bodies' in the process of providing nursing care to nursing home residents	Qualitative study with 13 nursing students and their 13 preceptors in parallel.	Ageism (prejudice based on age of patient)
35	Rojas, 2011	Colombia	To explore the nurse's experiences of caring for Indigenous patients in hospitalization	Qualitative study with Acute Care Hospital 20 RNs/LPNs	Racism (discrimination based on ethnicity)
36	Ropero-Padilla et al., 2022	Spain	To develop insight into the experiences of LGBTQ+ community members to obtain in-depth perceptions of microaggressions and an understanding of their healthcare needs to provide safe and sensitive care	Qualitative study with 21 LGBTQ+ individuals at one local LGBTQ+ community association in Almeria	Homophobia (prejudice against individuals who are LGBTQ2+)
37	Rus, 2019	Spain	To validate an instrument to measure mental health stigma with future clinicians	Quantitative study with 837 participants in university and clinical settings (nursing students)	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
38	Sánchez-Ojeda, 2018	Spain	To explore attitudes of nursing students at the University of Granada towards immigrant patients	Quantitative study with two studies at a university with students. First: ExPost Facto with 891 participants. Second: Quasi-experimental with 356 participants	Sexism (discrimination based on gender; male being the norm)
39	Sánchez-Ojeda et al., 2019	Spain	To determine whether nursing students have subtle or blatant prejudices towards migrants	Mixed Methods study with 282 nursing students and the study variables were sex, cultural origin, age, year, and contact with migrants	Racism (discrimination based on ethnicity)

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
40	Shea & Gagnon, 2015	Canada	To examine the experiences of Intensive Care Unit (ICU) nurses who work with PLWO (Persons Living with Obesity)	Qualitative study with 11 ICU nurses from two different units of a 1155 bed, multisite, tertiary care health center located in a large urban center in eastern Ontario	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
41	Steele & Melby, 1995	UK	To investigates nurses' beliefs, knowledge and perceptions of risk of contracting HTV while implementing their nursing care	Quantitative study with 42 RNs in the hospice, hospital and community settings	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)
42	Sundborg et al., 2017	Sweden	To improve the understanding of district nurses' experiences of encountering women exposed to intimate partner violence	Qualitative study with interviewing 11 district RNs (female no males worked at the chosen sites) in primary health care in Sweden	Sexism (discrimination based on gender; male being the norm)
43	Varcoe, 2001	Canada	To describe nursing practice in relation to violence against women	Qualitative study of 2 hospital emergency units Participant observation and interviews with 25 healthcare providers, 5 patients in the 2 units, and 5 nurses from other emergency units	Sexism (discrimination based on gender; male being the norm)
44	Waller et al., 2012	USA	To determine the implicit or unconscious attitudes of Nursing and Psychology majors towards overweight individuals	Quantitative study with 45 nursing students and 45 and psychology students	Discrimination based on disease (prejudice based on disease HIV/AIDS, Mental Health - for example)

Contributors of Conscious and Unconscious Biases in the Nursing Profession.

Despite a nurse's professed commitment to egalitarian principles, unconscious or conscious biases may be triggered by hidden perceptions, attitudes, or memories and have damaging consequences for an ISHC (Narayan, 2019). Bias was demonstrated through notions of color blindness, exemplified by a nurse's statement, "Our job is to break down culture. No matter how hard I teach the minute I leave they go back to their cultural way!!!" (Cassata & Dallas, 2005). Beyond ethnocentrism (Karatay et al., 2016; Varcoe, 2001), researchers also observed a preferential bias regarding resource allocation. Specifically, there was a widespread belief that available, limited health resources should prioritize acutely ill populations over older adults (Lovi & Barr, 2009; Rababa et al., 2020). This resulted in limited access to healthcare or

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

a decreased quality of care provided (Haghiri-Vijeh, 2022; Ming et al., 2019; Steele & Melby, 1995; Zrinyi & Balough, 2004). Another category was the savior complex, where nurses believed they knew what was best for an ISHC (Cassata & Dallas, 2005; Ihalainen-Tamlander et al., 2016). The savior complex was evident when nurses failed to consider cultural diversity in care planning, resulting in the return of ISHC to their cultural health practices (Cassata & Dallas, 2005). The assumption that ISHC always has a choice in their situation or that the circumstances are their fault (Frazer et al., 2010; Lovi & Brar, 2009; Shea & Gagnon, 2015; Sundborg et al., 2017). A main contributor to potential bias and violations by nurses was education, as well as life and professional experiences. Formal education and previous work experiences were found to increase the nurse's level of compassion and decrease violations toward ISHC (Frazer et al., 2011; Kantrowitz-Gordon et al., 2022; Malfait et al., 2017; Nagothu et al., 2018; Rus, 2019; Steele & Melby, 1995). In many studies, acquiring additional specialized education positively correlated with beneficial attitudes toward care (Frazer et al., 2011; Ihalainen-Tamlander et al., 2016; Nagothu et al., 2018; Robinson & Cubit, 2005).

Table 1. Study findings (Continued).

No	Authors, year	Country	Aims	Method	Type of discrimination/ oppression
45	Xiao et al., 2013	Australia	To compare Australian and Chinese nursing students' attitudes and intentions to care for the elderly and the factors affecting these intentions	Quantitative study with two surveys of 256 Australian nursing students and 204 Chinese nursing students within the first weeks of their nursing curriculum	Ageism (prejudice based on age of patient)
46	Zrinyi & Balogh, 2004	Hungary	To describe attitudes of nursing students (and paramedic officers) towards marginalized clients	Mixed methods study with 250 nursing students attending a four-year Bachelor of Science in Nursing (BSN) education program of a large nursing school in Budapest, Hungary	Classism (prejudice based on social place in society)

There was also a noted lack of education to explore conscious and unconscious biases and resulting care for the following groups: older adults (Rababa et al., 2020), adolescents (Coelho et al., 2016), stigmatized diseases such as HIV/AIDS or hepatitis (Frazer et al., 2011; Nagothu et al., 2018), the LGBTQ2S+ community (Ropero-Padilla et al., 2022), those living with mental health challenges (Ihalainen-Tamlander et al., 2016; Jacq et al., 2021; Kantrowitz-Gordon et al., 2022), and substance use disorder (Kantrowitz-Gordon et al., 2022). The deficiency in education and experience correlated to negative attitudes and actions toward certain groups of ISHC (Gabrielson, 2011; Ihalainen-Tamlander et al., 2016; Jacq et al., 2021; Rababa et al., 2020; Ropero-Padilla et al., 2022). Koch and Webb (1996) observed that in the care of the elderly, individual needs are often disregarded in favor of rigid standardized routines. This approach reduces care to basic needs such as hygiene and medication on a strict schedule, with limited attention to individual preferences or conditions, in addition to segregation (Koch & Webb, 1996). Haghiri-Vijeh (2022) noted that migrants and members of the LGBTQ2S+ community often face additional scrutiny and are subjected to further tests or vaccines, illustrating the pervasive nature of heteronormative bias within the healthcare system. Evidence revealed the existence of coercive practices arising from the authoritarian enforcement of medication and treatment. Furthermore, the prevalent use of sedation to manage agitation contributed to a culture of impersonal and standardized care within mental health settings (Ihalainen-Tamlander et al., 2016; Reed & Fitzgerald, 2005). While Ropero-Padilla et al. (2022) highlighted a deficit in inclusive initiatives, it was furthermore evident that the social identity and location of ISHCs were largely unacknowledged or deemed unimportant.

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Medicalizing Rationality

The findings demonstrated a medicalized rationality, characterized by an objectifying focus on the patient's biomedical needs rather than a holistic view of the person as a whole. The scoping review highlighted articles focusing on racist violations by nurses as a reflection of societal norms (Cano & Sánchez, 2018; Cassata & Dallas, 2005; Castillo Parra et al., 2018; Cioffi, 2005; Gil Estevan & Solano-Ruiz, 2017a, 2017b; Karatay et al., 2016; Rojas, 2011; Sánchez-Ojeda, 2018; Sánchez-Ojeda et al., 2019). The multiplicity of migratory processes has promoted major social and organizational changes in today's society. Belonging to equity seeking groups represents a factor of vulnerability and generates micro-social barriers that hinder access to health services, among other areas. The phenomenon of subtle and everyday racism goes unnoticed by nursing professionals. However, it affects caregivers who are accused of not abiding by the norms and values of the dominant population and culture (Gil Estevan & Solano-Ruiz, 2017a, 2017b). In general, linguistic and cultural barriers, prejudices, and stereotypes hinder the establishment of the therapeutic relationship between nurses and patients (Rojas, 2011). The literature indicates that nurses who belong to equity-seeking groups, or those who have received education on cultural humility and safety, are more receptive to meeting the needs of ISHCs. Conversely, this openness is often lacking among professionals whose practice is burdened by evident conscious or unconscious biases and prejudices (Sánchez-Ojeda, 2018; Sánchez-Ojeda et al., 2019)

A key theme emerging from the articles was the pervasive failure to recognize how an ISHC's unique social location and cultural background shape their health-seeking behaviors and, consequently, the design of appropriate nursing interventions (Karatay et al., 2016). This exclusion is also evident in the discrimination towards individuals who identify on the LGBTQ2S+ spectrum as a decrease in access to necessary resources and quality healthcare interactions (Carabez & Scott, 2016; Gabrielson, 2011; Haghiri-Vijeh, 2022; Klotzbaugh & Spencer, 2014; Merryfeather & Bruce, 2014; Reed & Fitzgerald, 2005; Ropero-Padilla et al., 2022). Homophobia and transphobia within healthcare can lead to nurses deadnaming and misgendering ISHCs, such as by using a patient's rejected birth name rather than their chosen name. Furthermore, these biases can manifest in a refusal to acknowledge a patient's partner or spouse as a legal agent for medical decision-making. ISHC spoke of the perceived need to remain invisible, conceal their identity by passing as heterosexual, and ignore active hostility and discrimination simply to receive a minimum standard of care. Additionally, the lack of knowledge on the part of nursing professionals and deficits in current curricula increase perceived barriers to care for transgender individuals (García-Acosta et al., 2019, 2020). This judgement of those who are violated is also noted in the articles focusing on individuals living with mobility challenges (Matziou et al., 2009), houseless (Zrinyi & Balogh, 2004), those formerly incarcerated (Marlow et al., 2015), and less familiarity with healthcare (Ming et al., 2019). Nurses were observed withholding care, using force for a lack of adherence, fostering stereotypes, and lacking engagement in collaborative decision-making (Marlow et al., 2015; Matziou et al., 2009; Ming et al., 2019; Zrinyi & Balogh, 2004). There was some evidence that healthcare professionals felt ISHC had a choice but lacked motivation for having alternative circumstances (Zrinyi & Balogh, 2004).

Discussion

According to Roach's (2002) framework, nurses have an ethical imperative to foster acceptance and ground their actions in an authentic reflection of shared humanity. The review highlighted instances of dehumanization that occurred precisely when nurses failed to recognize these complexes lived realities. Instances of dehumanization were documented in the care of vulnerable populations, including those experiencing aging, obesity, physical challenges, and intimate partner violence. In these cases, an asymmetrical power structure reinforced a dominant professional nursing stance, leading to hierarchical rather than collaborative and supportive relationships (Guix et al., 2006; Jenkins et al., 2024). Many authors, as reflected in the identified themes, focused narrowly on the deficits experienced (e.g., aging, HIV/AIDS, mental health challenges), without attending to the emotional, spiritual, or broader life concerns that shape a more holistic understanding of who the ISHC is. Failing to adopt a holistic approach ultimately depersonalizes the ISHC, treating the patient as an object to work on rather than a partner to work with (Narayan, 2019; Roach, 2002; Van Herk et al., 2011). Nurses' biases directly impacted their clinical views and care delivery, particularly regarding individuals navigating mental health challenges (González, 2012; Jacq et al., 2021; Kantrowitz-Gordon et al., 2022), communicable diseases (Steele & Melby, 1995), Abortion care (Alonso-Muñiz & Arias-Lopez, 2022). Together, these data highlight a systematic objectification and stigmatization that strips patients of their individual humanity.

An authentic relationship promotes acknowledging and accepting the ISHC's unique circumstances (Van Herk et al., 2011). Thus, an ethical response grounded in awareness of context calls forth a relational responsibility as a nurse (Roach, 2002). The absence of an ethical framework drives dehumanization, focusing strictly on the medical diagnosis while ignoring or dismissing the ISHC's cultural diversity and humanity (Roach, 2002). As a result of nursing education

grounded in Eurocentric values and culture, study identified how some nurses noted that they did not understand the lived experiences of ISHC beyond the care of the body (Cassata & Dallas, 2005). The findings indicate that a nurse's level of education regarding ISHCs, combined with their personal values and beliefs, directly shapes both conscious and unconscious biases (Ihalainen-Tamlander et al., 2016; Nagothu et al., 2018). These stereotypes, in turn, heavily influence subsequent nursing practices. Lack of education on caring older adults (Rababa et al., 2020), adolescents (Coelho et al., 2016), LGBTQ2S+ (Ropero-Padilla et al., 2022), and those living with mental health challenges (Jacq et al., 2021; Kantrowitz-Gordon et al., 2022) correlated to negative attitudes and nursing care. Additional research indicates that formal curricula emphasizing critical self-reflection, cultural humility, and safe care for equity-seeking groups correlate with a more positive and empathetic approach to nursing practice (Maykut, 2021; Narayan, 2019; Van Herk et al., 2011).

These findings emphasize that nursing curricula must commit to ensuring students recognize the importance of diverse ISHC needs and organizational standards. The curricula must equip learners to implement safe and anti-discriminatory care practices (Canadian Association of Schools of Nursing [CASN] (2022). The classic pedagogical models of nursing education inherently position the instructor in a place of power and privilege over learners. Consequently, nurses may internalize this hegemonic perspective, later replicating a 'power-over-others' dynamic in clinical practice by dismissing or devaluing the realities, concerns, and active contributions of ISHCs toward their own care (Marlow et al., 2015; Ming et al., 2019; Narayan, 2019). A focus on cultural humility and safety is essential in enabling nurses to critically examine and address the power imbalances and stereotypes that influence care delivery (Canadian Association of Schools of Nursing [CASN], 2022). Instead, nursing education must center on intersectionality and cultural context. This approach requires educators to acknowledge the diverse needs of individuals while ensuring that patients are never reduced to a single social category or rigid group identity (Canadian Association of Schools of Nursing [CASN], 2022). Engagement with cultural context and diversity requires moving beyond surface-level demographics to understand the complex, intersectional lived experiences of the individual (Foronda et al., 2016; Mallette & Yonge, 2026). Cultural diversity also encompasses a range of concepts, including values and beliefs, social power and class, language, sexuality, lifestyles, and health disparities (Foronda et al., 2016; Mallette & Yonge, 2026). Emphasizing diversity is essential for promoting understanding, inclusivity, awareness of conscious and unconscious biases (Maykut, 2021; Narayan, 2019; Van Herk et al., 2011). Such an approach can help shift nursing practice away from rigid, standardized routines and the authoritarian enforcement of treatments toward a model focused on the individual's unique needs (Roach, 2002; Van Herk et al., 2011).

From a Foucauldian perspective, the scoping review findings indicate that nurses can be submerged in a medicalizing rationality. A Foucauldian perspective functions as a critical framework for analyzing the ways in which power circulates through nursing care, shaping subjectivities and reinforcing normative assumptions and stereotypes of care practices and relationships (Holmes & Gagnon, 2018). On the other hand, this produces a docile profession who does not question policies, procedures and the traditional hierarchical delivery of patient care, making it functional to the hegemonic health systems. Yet, this distances the discipline from its fundamental ethical principles and its ideal purpose (Jenkins et al., 2024). As anti-establishment perspectives, populism and nativism intersect to restrict societal resources and policy protections exclusively to individuals validated by the dominant culture (Betz, 2019; Felder et al., 2021; Ortiz-Millán, 2024). Labelling ISHC as either good/bad, worthy/unworthy, and accepted/rejected establishes an us-versus-them and power over mentality (Crenshaw, 1989; Hankivsky & Christoffersen, 2008). This mentality influences how power, privilege and oppression are expressed in actions and language in nursing practice towards those who are being violated due to their diversity and who they are as a person. A lack of an ethical imperative perpetuates these perspectives, thereby increasing exclusion for certain members of our society (Roach, 2002). Previous examples highlight both the internal (individual) and external (group and society) influences on excluding groups of individuals (Crenshaw, 1989; Hankivsky & Christoffersen, 2008). As unique social locations for ISHC and nurses, cultural diversity has resulted in an increased awareness and recognition of a person's intersectionality and their individual needs (Mallette & Yonge, 2026). This diversity requires a shift from cultural competence to safety and humility to ensure the ISHC's healthcare needs are contextualized as their lived experiences (Reeves et al., 2024).

The purpose of this review was to map evidence regarding nurse-led oppression rather than to answer a specific clinical question or offer immediate mitigative solutions. In accordance with standard scoping review protocols, the 46 retrieved articles were not assessed for methodological rigor, author bias, or findings quality (Peters et al., 2020). This approach introduces several distinct limitations. First, the findings lack immediate practical application for generating clinical guidelines and policies. Second, the broad scope of the search parameters restricted the opportunity for a deeper, more granular analysis of the phenomena. Third, while knowledge gaps were successfully identified, actionable recommendations and prospective research questions were excluded from the scope of this discussion. Finally,

because the professional interpreters utilized did not have specialized backgrounds in healthcare, semantic nuances may have been lost during translation.

Conclusion

The review was the first to examine the intersection of power, privilege and oppression by nurses towards individuals seeking healthcare, particularly acts of dehumanization. Believing compliance with sanctioned institutional regulations is paramount, professionals often overlook oppressive and dehumanizing practices (Baptista et al., 2018; Jenkins et al., 2024). Disrupting these practices requires a critical-reflexive agenda that employs an intersectional lens to illuminate the unique, complex factors shaping an individual's fluid social location and identity. Without this critical awareness, unconscious bias triggers may result in oppressive acts by nurses towards ISHC (Storm et al., 2023). Respect for human dignity compels nurses to reflect on the power asymmetries inherent in care relationships, upholding an ethical imperative that transcends the efficiency of current health systems (Herrera & Granados, 2024). To avoid complicity in dehumanizing ISHC, professional nurses must accept the responsibility of confronting those who perpetrate these violations (Merryfeather & Bruce, 2014). Although this scoping review explored acts of violation, it does not intend to undermine the exemplary work being championed across practice settings in mitigating the phenomenon. Nor was it to suggest or label the whole of the nursing profession as oppressive, unethical, and/or perpetrators of acts of violations.

The findings serve as a call to action for all administrators, clinicians, educators, nursing students, policymakers, and researchers to engage in this uncomfortable yet necessary discourse to mitigate harm and prevent future occurrences. This requires a professional commitment to ensure congruence with ethical imperatives. Nurses must engage in a continuous, in-depth examination of their personal beliefs and values. Critical awareness of their own social location and identity enables nurses to understand how power, privilege, and oppression intersect within their professional roles, ultimately helping to prevent violations. This requires engagement in critical reflexivity with others as an opportunity to extend phronesis, which promotes diversity of thought, which may promote inclusion. Finally, nurses are called to be witnesses. They must confront individuals who perpetrate violations and challenge organizations to enact policies that combat this complex issue (Persaud, 2019). Nurses must speak up, show up, and stand up against violations that dehumanize individuals, reinforce conscious and unconscious biases, and sustain medicalizing rationality.

Future studies should critically examine how dominant narratives and hegemonic processes and structures alienate and dehumanize ISHC and thus perpetuate trauma and violence. Studies might focus on how nurses come to understand themselves and others within caring encounters, attending to how identities, such as competent nurse and compliant patient, are shaped through discourse and embedded power relations. Such inquiries may highlight how nurses/nursing profession both reproduce and resist these discourses in practice, offering possibilities for fostering critical reflexivity and advancing a more equitable and contextually responsive approach to care. Understanding how these dominant discourses shape professional identities, construct norms of care, and perpetuate or disrupt stereotypes and inequities is relevant for nursing curricula development. Of particular interest is how nursing education/faculty socialize students into constructed truths regarding professionalism, competence, and the hierarchy of ISCH; thereby informing assumptions about whose lives matter most.

Acknowledgments

The authors sincerely thank Ms. Antonia Arias and Mr. Sebastian Cruz Ferrin for their exceptional assistance and patience with interpretation throughout this project. Their contributions allowed us to expand the review to include four languages and additional databases, significantly increasing the robustness of the study. We also extend our deepest appreciation to Dr. Khaldoun Aldiabat, Dr. Peggy Chinn, Dr. Elizabeth Madigan, and Dr. Jess Dillard-Wright; their valuable insights and unwavering belief in the importance of this topic inspired us to persevere through to publication.

AI statements

During discussions, ChatGPT® supported the translation and articulation of ideas to inform and deepen dialogue amongst the authors. Also, in the preparation of this manuscript, the authors utilized Grammarly® to improving the clarity and readability. All generated content was critically reviewed and revised by the authors all of whom assume full responsibility for the integrity and accuracy of the final publication.

Author's declaration

Colleen Ann Maykut: Conceptualization, methodology, investigation, formal analysis, project administration, writing – original draft & editing. Yamileth Castano Mora: Conceptualization, methodology, investigation, formal analysis, writing –

original draft & editing. Beatriz Elena Arias Lopez: Investigation, methodology, investigation, formal analysis, writing – original draft & editing. Hanna Ouellette: Investigation, formal analysis, writing – original draft & editing. Claire Mallette: Conceptualization, methodology, investigation, formal analysis, writing - editing.

Availability of data and materials
The data that supports the findings are available in the supplementary material of this article **(Table 1)**.

Competing interests
There are no conflicts of interest to report.

Ethical clearance
Not applicable.

Funding
The authors did not receive any financial grants from funding agencies in the public, commercial, or not-for-profit sectors for the conduct of this review.

Publishers and journal's note
This review article introduces a novel concept: 'violations in a shared humanity,' which is essential for hospital-based healthcare professionals to understand. The scoping review design is highly appropriate for achieving the study's objectives. The findings fully align with the editor's expectations, and this article is poised to make a significant impa ct on global nursing practice.

References

Alonso-Muñiz, G. R., & Arias-López, B. E. (2022). ¿ Qué se preguntan las enfermeras/os sobre el aborto? Una revisión panorámica. *Revista Ciencia y cuidado, 19*(3), 96-111. https://doi.org/10.22463/17949831.3321

Ammann, C., Mall, J., Richter, M., & Thieme, S. (2021). Negotiating social differences and power geometries among healthcare professionals in a Swiss hospital. *Gender, Place & Culture, 28*(12), 1715-1737. https://doi.org/10.1080/0966369X.2020.1847047

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K. B., Reimer Kirkham, S., Lynam, J., Semeniuk, P., & Smye, V. (2003). Riting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science, 26*(3), 196–214. https://doi.org/10.1097/00012272-200307000-00005

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Arsianian-Engoren, C. (2000). Gender and age bias in triage decisions. *Journal of Emergency Nursing, 26*(2), 117-124. https://doi.org/10.1016/S0099-1767(00)90053-9

Atwood, J. D., & Scholtz, C. (2005). Power differentials in relationships: Who's the boss? Assessment and therapeutic considerations. *Journal of Couple & Relationship Therapy, 4*(4), 57-77. https://doi.org/10.1300/J398v04n04_04

Australian Institute of Health and Welfare. (2022). *People with disability in Australia*. https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/summary

Baptista, M. K. S., Santos, R. M. dos, Costa, L. de M. C., Macêdo, A. C. de, & Costa, R. L. M. (2018). O poder na relação enfermeiro-paciente: Revisão integrativa. *Revista Bioética, 26*(4), 556-566. https://doi.org/10.1590/1983-80422018264274

Betz, H. G. (2019). Facets of nativism: A heuristic exploration. *Patterns of Prejudice, 53*(2), 111-135. https://doi.org/10.1080/0031322X.2019.1572276

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *The Permanente Journal, 15*(2), 71-78. https://doi.org/10.7812/tpp/11.979

Bochatay, N., Kuna, Á., Csupor, É., Pintér, J. N., Muller-Juge, V., Hudelson, P., ... & Kim, S. (2021). The role of power in health care conflict: Recommendations for shifting toward constructive approaches. *Academic Medicine, 96*(1), 134-141. https://doi.org/ 10.1097/ACM.0000000000003604

Burke, M. (2020, November 6). *Death of Black mother after birth of child highlights racial disparities in maternal mortality*. NBC News. https://www.nbcnews.com/news/us-news/death-black-mother-after-birth-first-child-highlights-racial-disparities-n1246841

Campbell-Heider, N., & Pollock, D. (1987). Barriers to physician-nurse collegiality: An anthropological perspective. *Social Science & Medicine, 25*(5), 421-425. https://doi.org/10.1016/0277-9536(87)90166-3

Canadian Association of Schools of Nursing. (2022). *National Nursing Education Framework*. Www.casn.ca. https://www.casn.ca/eas/resources/national-education-framework

Canadian Federation of Nurses Unions. (2025). *Apology to Indigenous Peoples*. Nursesunions.ca. https://reconciliation.nursesunions.ca/

Canadian Nurses Association. (2024a). *Code of Ethics for Nurses - Canadian Nurses Association*. Www.cna-Aiic.ca. https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics/2025-coe

Canadian Nurses Association. (2024b). *Racism in Health Care - Canadian Nurses Association*. Www.cna-Aiic.ca. https://www.cna-aiic.ca/en/policy-advocacy/advocacy-priorities/racism-in-health-care

Cano, M. C., & Sánchez, C. S. (2018). Cuidados y diversidad cultural: un estudio de caso en un centro de Atención Primaria en Murcia. *Cultura De Los Cuidados*, (50), 127–140. https://doi.org/10.14198/cuid.2018.50.12

Carabez, R., & Scott, M. (2016). 'Nurses don't deal with these issues': Nurses' role in advance care planning for lesbian, gay, bisexual and transgender patients. *Journal of Clinical Nursing, 25*(23-24), 3707-3715. https://doi.org/10.1111/jocn.13336

Cassata, L., & Dallas, C. (2005). Nurses' attitudes and childbearing adolescents: Bridging the cultural chasm. *The ABNF Journal, 16*(4), 71–76. https://pubmed.ncbi.nlm.nih.gov/16144146/

Castillo Parra, S. D. C., Quijada Sánchez, D. C., Feliú Pérez, D. S., Paz Fernández Torres, R., Molina Sevilla, O. J., Monsalves Morales, M. F., & Otay Ríos, V. E. (2018). Percepción de enfermería respecto a la atención hospitalaria otorgada a personas que viven con VIH. *Enfermería: Cuidados Humanizados, 7*(2), 36-62. https://doi.org/10.22235/ech.v7i2.1643

Cioffi, J. (2005). Nurses' experiences of caring for culturally diverse patients in an acute care setting. *Contemporary Nurse, 20*(1), 78-86. https://doi.org/10.5172/conu.20.1.78

Coelho, M. de M. F., Miranda, K. C. L., Gomes, A. M. T., & Silveira, L. C. (2016). Construções ideológicas em práticas educativas de enfermagem com adolescentes [Ideological constructions in nursing education practices with adolescents] [Construcciones ideológicas en prácticas educativas de enfermería con adolescentes]. *Revista Enfermagem UERJ, 24*(5), e9947. https://doi.org/10.12957/reuerj.2016.9947

Collins, L. H. (2000). Creating gender role behavior: Demonstrating the impact of power differentials. *Teaching of Psychology, 27*(1), 37-40. https://doi.org/10.1207/S15328023TOP2701_8

Comeau, D., Johnson, C., & Bouhamdani, N. (2023). Review of current 2SLGBTQIA+ inequities in the Canadian health care system. *Frontiers in Public Health*, 11. https://doi: 10.3389/fpubh.2023.1183284

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), Article 8. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Dong, D., & Temple, B. (2011). Oppression: A concept analysis and implications for nurses and nursing. *Nursing Forum, 46*(3), 169-176. https://doi.org/10.1111/j.1744-6198.2011.00228.x

Engel, J., Prentice, D., & Taplay, K. (2017). A power experience: A phenomenological study of interprofessional education. *Journal of Professional Nursing, 33*(3), 204-211. https://doi.org/10.1016/j.profnurs.2016.08.012

Essex, R., Kennedy, J., Miller, D., & Jameson, J. (2023). A scoping review exploring the impact and negotiation of hierarchy in healthcare organisations. *Nursing Inquiry*, e12571. https://doi.org/10.1111/nin.12571

Felder, M., Wallenburg, I., Kuijper, S., & Bal, R. (2021). Taking the relationship between populism and healthcare seriously: A call for empirical analysis rather than moral condemnation comment on" A scoping review of populist radical right parties' influence on welfare policy and its implications for population health in Europe". *International Journal of Health Policy and Management, 10*(9), 598. https://doi.org/10.34172/ijhpm.2020.180

Firpo, R. E. (2021). Epistemología en Enfermería. Una revisión del acto de cuidar desde Michel Foucault, el modelo de Roper, Logan & Tierney y el concepto de "bildung" de Gadamer. *Hermeneutic,* (19), 42-55. https://doi.org/10.22305/hermeneutic-unpa.n19.a2021.765

Fleming, P., & Spicer, A. (2014). Power in management and organization science. *The Academy of Management Annals, 8*(1), 237–298. https://doi.org/10.1080/19416520.2014.875671

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210-217. https://doi.org/10.1177/1043659615592677

Frazer, K., Glacken, M., Coughlan, B., Staines, A., & Daly, L. (2011). Hepatitis C virus in primary care: Survey of nurses' attitudes to caring. *Journal of Advanced Nursing, 67*(3), 598-608. https://doi.org/10.1111/j.1365-2648.2010.05516.x

Gabrielson, M. L. (2011). "I will not be discriminated against": Older lesbians creating new communities. *Advances in Nursing Science, 34*(4), 357-373. https://doi.org/10.1097/ANS.0b013e3182300db8

García-Acosta, J. M., Castro-Peraza, M. E., Perestelo-Pérez, L., Rivero-Santana, A., Arias-Rodríguez, Á., & Lorenzo-Rocha, N. D. (2020). Measuring explicit prejudice and transphobia in nursing students and professionals. *Nursing Reports, 10*(2), 48-55. https://doi.org/10.3390/nursrep10020008

García-Acosta, J., Castro, M., Arias, M., Llabrés, R., Lorenzo, N., & Perdomo, A. (2019). Atención sanitaria trans* competente, situación actual y retos futuros Revisión de la literatura. *Enferm Glob, 18*(4), 529-54. http://doi.org/10.6018/eglobal.18.4.357621

Geary, A. (2017, September 19). *Ignored to death: Brian Sinclair's death caused by racism, inquest inadequate, group says*. CBC News. https://www.cbc.ca/news/canada/manitoba/winnipeg-brian-sinclair-report-1.4295996

Gil Estevan, M. D., & Solano-Ruiz, M. D. C. (2017a). La aplicación del modelo de competencia cultural en la experiencia del cuidado en profesionales de Enfermería de Atención Primaria. *Atención Primaria, 49*(9), 549-556. https://doi.org/10.1016/j.aprim.2016.10.013

Gil Estevan, M. D., & Solano-Ruiz, M. D. C. (2017b). *Las enfermeras opinan: mujeres gitanas, lactancia materna y cuidados de enfermería en Atención Primaria*. Repository University of Alicante. https://rua.ua.es/entities/publication/cd65ac8c-af1d-4e90-8f52-4c951ac8ba9e/full

González, M. C. (2012). Conflictos éticos derivados de cuidar a pacientes drogodependientes. *ENE Rev Enferm, 6*(1), 61-70. https://dialnet.unirioja.es/servlet/articulo?codigo=3906586

Government of Canada. (2021, June 23). *Call to Action on Anti-Racism, Equity, and Inclusion in the Federal Public Service* - Privy Council Office - Canada.ca. Www.canada.ca. https://www.canada.ca/en/privy-council/corporate/clerk/call-to-action-anti-racism-equity-inclusion-federal-public-service.html

Haghiri-Vijeh, R. (2022). Experiences of LGBTQIA+ migrants with nurses and other healthcare professionals in Canada. *Nursing Forum, 57*(6), 1184–1192. https://doi.org/10.1111/nuf.12819

Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health, 18*(3), 271-283. https://doi.org/10.1080/09581590802294296

Hart, R. (2021). *Transgender people twice as likely to die as cisgender people, study finds*. Forbes. https://www.forbes.com/sites/roberthart/2021/09/02/transgender-people-twice-as-likely-to-die-as-cisgender-people-study-finds/

Herrera, N. H. R., & Granados, D. G. (2024). Asimetría y abuso de poder en la relación profesional sanitario – paciente. *Diafanís Arte, Ciencia y Comunicación, 7*(20), 217-232. https://doi.org/10.1590/1983-80422018264274

Holmes, D., & Gagnon, M. (2018). Power, discourse, and resistance: Poststructuralist influences in nursing. *Nursing Philosophy, 19*(1), 10.1111/nup.12200. https://doi.org/10.1111/nup.12200

Ihalainen-Tamlander, N., Vähäniemi, A., Löyttyniemi, E., Suominen, T., & Välimäki, M. (2016). Stigmatizing attitudes in nurses towards people with mental illness: A cross-sectional study in primary settings in Finland. *Journal of Psychiatric and Mental Health Nursing, 23*(6-7), 427-437. https://doi.org/10.1111/jpm.12319

Infobae. (2022, October 1). *A la cárcel enfermero del hospital La Victoria denunciado por abuso sexual contra seis de sus pacientes*. Infobae. https://www.infobae.com/america/colombia/2022/10/01/a-la-carcel-enfermero-del-hospital-la-victoria-denunciado-por-abuso-sexual-contra-seis-de-sus-pacientes/

Jacq, K. D., Norful, A. A., & Larson, E. (2021). Nurses' and mental health technicians' attitudes and social acceptance of people with mental illness. *Issues in Mental Health Nursing, 42*(4), 365-375. https://doi.org/10.1080/01612840.2020.1799272

Jenkins, D., Wolfe, I., & Dillard-Wright, J. (2024). Nurses as disciplinary agents of the state: Ethical practice and mandatory reporting in the United States. *Advances in Nursing Science, 47*(4), 335–348. https://doi.org/10.1097/ANS.0000000000000503

Jojoa-Tobar, E., Cuchumbe-Sánchez, Y. D., Ledesma-Rengifo, J. B., Muñoz-Mosquera, M. C., Campo, A. M. P., & Suárez-Bravo, J. P. (2019). Violencia obstétrica: Haciendo visible lo invisible. Revista de la Universidad Industrial de Santander. *Salud, 51*(2), 135–146. https://doi.org/10.18273/revsal.v51n2-2019006

Joseph-Williams, N., Elwyn, G., & Edwards, A. (2014). Knowledge is not power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. *Patient Education and Counseling, 94*(3), 291-309. https://doi.org/10.1016/j.pec.2013.10.031

Kantrowitz-Gordon, I., Price, C., Rudolf, V., Downey, G., & Castagnola, K. (2022). Exploring perinatal nursing care for opioid use disorder: Knowledge, stigma, and compassion. *The Journal of Perinatal & Neonatal Nursing, 36*(4), 353-361. https://doi.org/10.1097/JPN.0000000000000587

Karatay, G., Bowers, B., Karadağ, E. B., & Demir, M. C. (2016). Cultural perceptions and clinical experiences of nursing students in Eastern Turkey. *International Nursing Review, 63*(4), 547-554. https://doi.org/10.1111/inr.12321

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. https://doi.org/10.1097/NNA.0000000000000103

Koch, T., & Webb, C. (1996). The biomedical construction of ageing: Implications for nursing care of older people. *Journal of Advanced Nursing, 23*(5), 954-958. https://doi.org/10.1046/j.1365-2648.1996.10014.x

Lovi, R., & Barr, J. (2009). Stigma reported by nurses related to those experiencing drug and alcohol dependency: A phenomenological Giorgi study. *Contemporary Nurse, 33*(2), 166-178. https://doi.org/10.5172/conu.2009.33.2.166

Malfait, S., Eeckloo, K., & Van Hecke, A. (2017). The influence of nurses' demographics on patient participation in hospitals: A cross-sectional study. *Worldviews on Evidence-Based Nursing, 14*(6), 455-462. https://doi.org/10.1111/wvn.12254

Mallette, C., & Yonge, O. (2026). *Arnold and Boggs's interpersonal relationships: Professional communication skills for Canadian nurses* (2nd ed.). Elsevier.

Marlow, E., Nosek, M., Lee, Y., Young, E., Bautista, A., & Hansen, F. T. (2015). Nurses, formerly incarcerated adults, and Gadamer: Phronesis and the Socratic dialectic. *Nursing Philosophy, 16*(1), 19-28. https://doi.org/10.1111/nup.12055

Matziou, V., Galanis, P., Tsoumakas, C., Gymnopoulou, E., Perdikaris, P., & Brokalaki, H. (2009). Attitudes of nurse professionals and nursing students towards children with disabilities. Do nurses really overcome children's physical and mental handicaps?. *International Nursing Review, 56*(4), 456-460. https://doi.org/10.1111/j.1466-7657.2009.00735.x

Maykut, C. (2021). Deconstructing identity: Professional relationships for sustaining morally habitable workplaces. *Archives of Psychiatric Nursing, 35*(2), 213-217. https://doi.org/10.1016/j.apnu.2020.07.021

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*(3), 179-191. https://doi.org/10.1111/nin.12042

McLane, P., Barnabe, C., Mackey, L., Bill, L., Rittenbach, K., Holroyd, B. R., ... & Rosychuk, R. J. (2022). First Nations status and emergency department triage scores in Alberta: A retrospective cohort study. *Canadian Medical Association Journal, 194*(2), E37-E45. https://doi.org/10.1503/cmaj.210779

McMillan, S. S., Kendall, E., Sav, A., King, M. A., Whitty, J. A., Kelly, F., & Wheeler, A. J. (2013). Patient-centered approaches to health care: A systematic review of randomized controlled trials. *Medical Care Research and Review, 70*(6), 567-596. https://doi.org/10.1177/1077558713496318

Merryfeather, L., & Bruce, A. (2014). The invisibility of gender diversity: Understanding transgender and transsexuality in nursing literature. *Nursing Forum, 49*(2), 110–123. https://doi.org/10.1111/nuf.12061

Ming, Y., Wei, H., Cheng, H., Ming, J., & Beck, M. (2019). Analyzing patients' complaints: Awakening of the ethic of belonging. *Advances in Nursing Science, 42*(4), 278-288. https://doi.org/10.1097/ANS.0000000000000278

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 27*(2), 175-182. https://doi.org/10.1111/j.1552-6909.1998.tb02608.x

Murray, R. (2022, September 26). *Acting on the evidence: Ensuring the NHS meets the needs of trans people*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/blogs/ensuring-nhs-meets-needs-trans-people

Nagothu, L. M., Tilekar, S. D., Sebastian, A. K., Fernandes, P. R., McCreary, L. L., & Norr, K. F. (2018). HIV-related stigma among nursing students attending a college of nursing that promotes nondiscriminatory care in India. *Journal of the Association of Nurses in AIDS Care, 29*(2), 241-253. https://doi.org/10.1016/j.jana.2017.11.008

Narayan, M. C. (2019). Addressing implicit bias in nursing: A review. *American Journal of Nursing, 119*(7), 36–43. https://doi.org/10.1097/01.NAJ.0000569340.27659.5a

Nerestant, A. (2021, Oktober 1). *Racism, prejudice contributed to Joyce Echaquan's death in hospital, Quebec coroner's inquiry concludes*. CBC News. https://www.cbc.ca/news/canada/montreal/joyce-echaquan-systemic-racism-quebec-government-1.6196038

O'Donoghue, D., Moritz, J., Hirst, L., & Lazaro, R. (2023, August 18). *Nurse Lucy Letby guilty of murdering seven babies on neonatal unit*. BBC News. https://www.bbc.com/news/uk-england-merseyside-65960514

Olivera, J. G., Ballarta, J. F., & Barbany, J. S. (2006). Pacientes, médicos y enfermeros: Tres puntos de vista distintos sobre una misma realidad. Actitudes y percepciones ante los derechos de los pacientes. *Gaceta Sanitaria, 20*(6), 465-472. https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S0213-91112006000600009

Ortiz-Millán, G. (2024). How populism affects bioethics. *Cambridge Quarterly of Healthcare Ethics*, 1-15. https://doi.org/10.1017/S0963180124000161

Parker, C. N., Harvey, T., Johnston, S., & MacAndrew, M. (2021). An exploration of knowledge of students and staff at residential aged care facilities and implications for nursing education. *Nurse Education Today, 96,* 104639. https://doi.org/10.1016/j.nedt.2020.104639

Parra, D. I., Peñaloza Jaimes, S. D., Cárdenas Villabona, M. V., Rey de Cruz, N., Amaya Díaz, H. C., Arboleda de Pérez, L. B., & Corredor Jurado, Y. (2019). Responsabilidades éticas en la práctica de enfermería en instituciones de alta complejidad. *Revista Cuidarte, 10*(3), e662. https://doi.org/10.15649/cuidarte.v10i3.662

Persaud, S. (2019). Addressing unconscious bias: A nurse leader's role. *Nursing Administration Quarterly, 43*(2), 130-137. https://doi.org/10.1097/NAQ.0000000000000348

Peters, M. D. J., Godfrey, C., McInerney, P., Munn, Z., Tricco, A. C., & Khalil, H. (2020). *Scoping reviews*. In E. Aromataris & Z. Munn (Eds.), JBI manual for evidence synthesis. JBI. https://synthesismanual.jbi.global

Rababa, M., Hammouri, A. M., Hweidi, I. M., & Ellis, J. L. (2020). Association of nurses' level of knowledge and attitudes to ageism toward older adults: Cross-sectional study. *Nursing & Health Sciences, 22*(3), 593-601. https://doi.org/10.1111/nhs.12701

Reed, F., & Fitzgerald, L. (2005). The mixed attitudes of nurse's to caring for people with mental illness in a rural general hospital. *International Journal of Mental Health Nursing, 14*(4), 249-257. https://doi.org/10.1111/j.1440-0979.2005.00389.x

Reeves, K., Job, S., Blackwell, C., Sanchez, K., Carter, S., & Taliaferro, L. (2024). Provider cultural competence and humility in healthcare interactions with transgender and nonbinary young adults. *Journal of Nursing Scholarship, 56*(1), 18-30. https://doi.org/10.1111/jnu.12903

Roach, M. S. (2002). *Caring, the human mode of being* (2nd rev. ed.). Catholic Health Authority Press.

Robinson, A., & Cubit, K. (2005). Student nurses' experiences of the body in aged care. *Contemporary Nurse, 19*(1-2), 41-51. https://doi.org/10.5172/conu.19.1-2.41

Rojas, J. G. (2011). *Significado de la experiencia de cuidar a pacientes Indígenas en las Salas de hospitalización del departamento de Antioquia-Colombia*. Dialnet. https://dialnet.unirioja.es/servlet/tesis?codigo=64909

Ropero-Padilla, C., Rodríguez-Valbuena, C., Rodriguez-Arrastia, M., Ruiz-Fernández, M. D., Roman, P., & Sanchez-Labraca, N. (2022). Exploring the microaggression experiences of LGBTQ+ community for a culturally safe care: A descriptive qualitative study. *Nurse Education Today, 115*, 105423. https://doi.org/10.1016/j.nedt.2022.105423

Rus, M. S. (2019). *Construcción y validación de una escala para la evaluación del estigma de la enfermedad mental en Enfermería*. Dialnet. https://dialnet.unirioja.es/servlet/tesis?codigo=266031

Sánchez-Ojeda, M. A. (2018). *Actitudes prejuiciosas de los estudiantes de enfermería de la Universidad de Granada ante Pacientes inmigrantes*. https://dialnet.unirioja.es/servlet/tesis?codigo=180091

Sánchez-Ojeda, M. A., Segura-Robles, A., Gallardo-Vigil, M. Á., & Alemany-Arrebola, I. (2019). Análisis de los prejuicios del alumnado de enfermería hacia la población migrante. *Revista da Escola de Enfermagem da USP, 53*, e03532. https://doi.org/10.1590/S1980-220X2018050103532

Shea, J. M., & Gagnon, M. (2015). Working with patients living with obesity in the intensive care unit: A study of nurses' experiences. *Advances in Nursing Science, 38*(3), E17-E37. https://doi.org/10.1097/ANS.0000000000000074

Simpson, J. (2009). *Everyone belongs: A toolkit for applying intersectionality* (1st ed.). Canadian Research Institute for the Advancement of Women. https://www.criaw-icref.ca/publications/everyone-belongs-a-toolkit-for-applying-intersectionality/

Steele, A., & Melby, V. (1995). Nurses' knowledge and beliefs about AIDS: Comparing nurses in hospital, community and hospice settings. *Journal of Advanced Nursing, 22*(5), 879-887. https://doi.org/10.1111/j.1365-2648.1995.tb02638.x

Storm, K. I. L., Reiss, L. K., Guenther, E. A., Clar-Novak, M., & Muhr, S. L. (2023). Unconscious bias in the HRM literature: Towards a critical-reflexive approach. *Human Resource Management Review, 33*(3), 1-32. https://doi.org/10.1016/j.hrmr.2023.100969

Sukhera, J., Bertram, K., Hendrikx, S., Chisolm, M. S., Perzhinsky, J., Kennedy, E., ... & Goldszmidt, M. (2022). Exploring implicit influences on interprofessional collaboration: A scoping review. *Journal of Interprofessional Care, 36*(5), 716-724. https://doi.org/10.1080/13561820.2021.1979946

Sundborg, E., Törnkvist, L., Saleh-Stattin, N., Wändell, P., & Hylander, I. (2017). To ask, or not to ask: The hesitation process described by district nurses encountering women exposed to intimate partner violence. *Journal of Clinical Nursing, 26*(15-16), 2256-2265. https://doi.org/10.1111/jocn.12992

Symenuk, P. M., Tisdale, D., Bourque Bearskin, D. H., & Munro, T. (2020). In search of the truth: Uncovering nursing's involvement in colonial harms and assimilative policies five years post Truth and Reconciliation Commission. *Witness: The Canadian Journal of Critical Nursing Discourse, 2*(1), 84–96. https://doi.org/10.25071/2291-5796.51

Tang, S. Y., & Browne, A. J. (2008). "Race" matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity & Health, 13*(2), 109–127. https://doi.org/10.1080/13557850701830307

Thirsk, L. M., Panchuk, J. T., Stahlke, S., & Hagtvedt, R. (2022). Cognitive and implicit biases in nurses' judgment and decision-making: A scoping review. *International Journal of Nursing Studies, 133,* 104284. https://doi.org/10.1016/j.ijnurstu.2022.104284

Thorne, S. (2025). *Interpretive description: Qualitative research for applied practice* (3rd ed.). Routledge. https://doi.org/10.4324/9781003503538

Turpel-Lafond, M. E. (2020). *In plain sight: Addressing indigenous-specific racism and discrimination in B. C. Health care*. Retrieved 27 May 2026, from https://baseline.bchumanrights.ca/report/in-plain-sight-addressing-indigenous-specific-racism-and-discrimination-in-b-c-health-care/

United Nations. (2026). *OHCHR | Special Rapporteur on the rights of Indigenous Peoples*. OHCHR. https://www.ohchr.org/en/special-procedures/sr-indigenous-peoples

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. https://doi.org/10.1111/j.1440-1800.2011.00539.x

Varcoe, C. (2001). An ethnographic account of emergency nursing in relation. *The Canadian Journal of Nursing Research, 32*(4), 95–115. https://pubmed.ncbi.nlm.nih.gov/11928304/

Waller, T., Lampman, C., & Lupfer-Johnson, G. (2012). Assessing bias against overweight individuals among nursing and psychology students: An implicit association test. *Journal of Clinical Nursing, 21*(23-24), 3504-3512. https://doi.org/10.1111/j.1365-2702.2012.04226.x

World Health Organization. (2024). *Constitution of the world health organization*. World Health Organization. https://www.who.int/about/governance/constitution

World Justice Project. (2023, March 21). *Discrimination is getting worse globally*. https://worldjusticeproject.org/news/discrimination-getting-worse-globally

Xiao, L. D., Shen, J., & Paterson, J. (2013). Cross-cultural comparison of attitudes and preferences for care of the elderly among Australian and Chinese nursing students. *Journal of Transcultural Nursing, 24*(4), 408-416. https://doi.org/10.1177/1043659613493329

Zrinyi, M., & Balogh, Z. (2004). Student nurse attitudes towards homeless clients: A challenge for education and practice. *Nursing Ethics, 11*(4), 334-348. https://doi.org/10.1191/0969733004ne707oa

JHNS
Journal of Holistic Nursing Science
E-ISSN: 2579-7751 P-ISSN: 2579-8472

Authors' insight

Key points

- The review introduces or maps a framework where certain interpersonal actions are not just labeled as errors or poor care, but are recognized as acts that strip individuals of their basic human dignity and common connection.
- The finding implies a focus on structural and systemic issues that allow healthcare professionals to overlook or inadvertently participate in dehumanizing practices.
- Addressing these acts in clinical practice through policy, legal recourse, and professional regulatory associations is mitigating harm towards individuals seeking healthcare.

Emerging nursing avenues

- How exactly does the literature define a violation of a shared humanity in a clinical context or nursing practice in hospitals?
- What concrete strategies or reflexive frameworks does this review suggest to help healthcare professionals (such as nurses) recognize their own positionality and actively disrupt these dehumanizing practices?
- What major geographic, linguistic, or methodological gaps did this scoping review uncover regarding how different global health systems document and address violations of human dignity?

How to cite this article (APA style)
Maykut, C. A., Mora, Y. C., Lopez, B. E. A., Ouellette, H., & Mallette, C. (2026). Violations of a shared humanity: A scoping review. *Journal of Holistic Nursing Science, 13*(1), 177–201. https://doi.org/10.31603/jhns.v13i1.14970