Electronic Journal of General Medicine
2025, 22(6), em701
e-ISSN: 2516-3507
https://www.ejgm.co.uk/

MODESTUM

Original Article

OPEN ACCESS

Diversity, equity, inclusion, and access: Confronting the myth of meritocracy in nursing academia

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Citation: Iheduru-Anderson K, Jayaraman R, Inungu J, Mumford VE. Diversity, equity, inclusion, and access: Confronting the myth of meritocracy in nursing academia. Electron J Gen Med. 2025;22(6):em701. https://doi.org/10.29333/ejgm/17437

ARTICLE INFO

Received: 26 May 2025

Accepted: 02 Oct 2025

ABSTRACT

This article critically examines how the enduring ideal of meritocracy obstructs diversity, equity, inclusion, and access (DEIA) in nursing education and leadership. While often framed as neutral and objective, meritocratic systems frequently reinforce exclusionary practices by privileging dominant norms and overlooking systemic barriers. Through historical analysis, policy critique, and theoretical frameworks, the paper demonstrates how DEIA initiatives are undermined by institutional resistance, hidden curricula, and performative equity efforts. The article calls for a redefinition of merit that centers equity, lived experience, and structural awareness. By embracing justice-oriented leadership and culturally responsive practices, nursing academia can advance both professional excellence and health equity. This equity-centered vision challenges institutions to dismantle outdated paradigms and align nursing education with its ethical and societal missions.

Keywords: nursing education, health equity, leadership, social justice, educational measurement, minority health

INTRODUCTION

Diversity, Equity, Inclusion, and Access (DEIA) have recently become central topics in discussions about nursing education and leadership—prompted not only by heightened commitments to social justice but also by a surge of political and legislative challenges. Although resistance to DEIA is not a new phenomenon, recent executive orders and policies from the current U.S. administration have intensified efforts to dismantle DEIA frameworks, penalize institutions for engaging in equity-centered initiatives, and characterize such efforts as politically controversial or divisive [1]. The resurgence of gag orders and book bans reflects not only policy shifts but also a broader ideological project aimed at suppressing dissent, controlling knowledge, and undermining the democratic mission of public education [2]. In this increasingly hostile environment, academic and healthcare institutions find themselves navigating complex tensions between public commitments to inclusion and political pressures to withdraw from them.

At the heart of these tensions is a persistent belief in meritocracy, the idea that success is determined by talent, hard work, and individual achievement. In nursing education and leadership, this belief has long functioned as a presumed neutral standard of excellence. Yet, in practice, meritocracy often conceals deeply rooted structural inequities that disadvantage individuals from historically marginalized communities. It reinforces existing hierarchies, legitimizes exclusion, and now, more than ever, provides convenient cover for undermining DEIA efforts under the guise of protecting objectivity and fairness.

This paper argues that the myth of meritocracy undermines Diversity, Equity, Inclusion, and Access (DEIA) efforts in nursing education and leadership by obscuring systemic inequities, reinforcing exclusionary norms, and providing ideological justification for political resistance to equity initiatives. In light of recent executive actions and institutional threats, this paper calls for a critical interrogation of meritocratic ideals and an urgent reimagining of nursing education and leadership through an equity-centered and justice-driven approach lens.

What Is DEIA—and What Is It Not?

Diversity, Equity, Inclusion, and Access (DEIA) are interconnected yet distinct concepts that together aim to transform institutions by addressing systemic disparities and promoting justice across various aspects such as race, gender, class, ability, language, and other social identities.

- Diversity refers to the presence and recognition of varied human differences and identities within a group, organization, or community [3]. It includes but is not limited to race, ethnicity, gender, religion, sexuality, disability, age, socioeconomic status, nationality, and language.
- Equity is about fairness in processes, access, and outcomes. Unlike equality, which treats everyone the same, equity acknowledges historical and structural barriers and allocates resources and opportunities in ways that aim to correct systemic disadvantages [3].

Table 1. Defining diversity, equity, inclusion, and access (DEIA) in nursing education

Terms	Definition	What it is not
Diversity	The presence of differences across identities, perspectives and lived experiences.	Tokenism or simply counting the number of underrepresented individuals.
Equity	Fairness in treatment, access, and outcomes by addressing structural and systemic barriers.	Equal treatment without consideration for different starting points (equality).
Inclusion	Creating environments where all individuals feel welcomed, valued, respected, and able to participate and contribute fully.	Assimilation or expecting marginalized people to adapt and conform to dominant norms.
Access	Removing structural, cultural, institutional, and systemic barriers that limit full participation or advancement.	Assuming availability equals accessibility for all.

Source: Adapted from [1, 3, 4, 71, 76]

- Inclusion focuses on the extent to which diverse individuals feel valued, welcomed, respected, and able to contribute fully within an environment [3]. It goes beyond representation to ask: Who is heard? Who has power? Who feels they belong?
- Access refers to the removal of structural, barriers—financial, physical, technological, systemic, curricular, linguistic, and cultural—that may prevent individuals from participating fully in educational and professional environments through reasonable accommodations [4].

As the American Association of Colleges of Nursing (AACN) powerfully affirms, "To improve the quality of nursing education, ameliorate health inequities, and advance leadership in the profession and society at large, the values and principles of diversity, inclusion, and equity must remain mission central" [5]. Diversity, equity, and inclusion help develop a nursing workforce ready to improve access and care quality for underserved and underrepresented groups [6]. This statement highlights the inseparability of DEIA from nursing's core educational and professional goals.

Importantly, DEIA does not aim to provide unfair advantages or dilute academic standards. Instead, it focuses on transforming structures that have historically favored some while excluding others. DEIA initiatives strive to rectify historical and systemic injustices and to cultivate a workforce that reflects and serves diverse communities with cultural humility and an equity-minded approach [4, 7].

DEIA impacts everyone, but it is especially essential for those historically excluded from higher education and nursing leadership—such as Black, Indigenous, and other people of color; LGBTQ+ individuals; people with disabilities; immigrants; and first-generation college students. Implementing DEIA in nursing education is essential not only for fairness within academia but also for building a profession capable of addressing the root causes of health disparities and inequity in healthcare systems. At its core, DEIA in nursing education is not a political agenda but a professional and ethical imperative [3, 8] that begins in the classroom. **Table 1** concisely compares the key terms—Diversity, Equity, Inclusion, and Access—alongside common misconceptions about each.

HISTORICAL AND STRUCTURAL CONTEXTS

The Legacy of Exclusion in Nursing Education and Leadership

Nursing education in the United States has been influenced by colonial and Eurocentric ideologies that determined who was deemed worthy of inclusion and advancement. These ideologies established whiteness, Western values, and upper-class norms as the standard for professionalism and competence [9, 10]. Florence Nightingale's legacy, while often celebrated, exemplifies historical exclusion. Nightingale's model of nursing formalized a white, British, upper-class vision of the "ideal nurse," whereas Mary Seacole, a Jamaican-born nurse of African and Creole descent who independently cared for soldiers during the Crimean War, was denied recognition by Nightingale and systematically erased from early professional nursing narratives [11-13]. As Pinto [10] argued, this erasure was not accidental; it was rooted in imperial logics that rewarded obedience, whiteness, and proximity to colonial power while marginalizing racialized women who challenged the dominant narratives hierarchies. Seacole's story illustrates how the foundations of nursing were built not just on clinical skill, but on social exclusion and racial gatekeeping.

These dynamics were not unique to nursing but reflected a broader pattern in U.S. higher education, which was founded on exclusionary practices that systematically marginalized people of color, women, and those from non-dominant religions and socioeconomic classes. As Museus et al. [14] note, the creation of Historically Black Colleges and Universities (HBCUs) and Tribal Colleges in the 19th century served as both a response to exclusion and a reflection of white institutions' unwillingness to serve racially minoritized students. Even policies like the Morrill Act of 1890, though presented as expanding opportunity, reinforced racial inequality by directing Black students toward vocational and agricultural education, perpetuating assumptions of inferiority and institutionalizing unequal opportunity [14, 15].

This early marginalization established a foundation for persistent racial and class-based exclusion in U.S. nursing education. Throughout the 20th century, Black, Indigenous, and other racially minoritized individuals were frequently denied admission to nursing schools or segregated into underfunded, racially separate institutions [16, 17]. Even after legal desegregation, they encountered structural and interpersonal racism in admissions, academic advising, and classroom interactions [17]. Class stratification also played a significant role, as the financial and social capital required to access nursing education excluded many working-class students and reinforced a hierarchy within the profession [16, 18].

Leadership pathways reflect these trends. Faculty and administrative roles have historically been held by white, middle- or upper-class individuals—mainly women until recent decades—who upheld norms and practices that supported cultural homogeneity and professional conformity [18-21]. Leadership opportunities for Black nurses and other underrepresented groups have been rare, often relying on overperformance or exceptional service—an embodiment of what has been termed the Black tax or cultural taxation [22-25].

Structural Barriers: Gatekeeping, Accreditation, and the Hidden Curriculum

Many of the exclusionary practices from nursing's past continue today through structural mechanisms that seem neutral but reinforce inequality. Admissions processes still depend heavily on standardized testing, GPAs, and unpaid clinical or volunteer experiences, all of which have been shown to disadvantage students from under-resourced schools and communities [26]. Holistic review processes, though promising, are applied inconsistently and often undervalued in competitive programs. This gatekeeping function favors applicants who conform to dominant norms and who have accessed academic and professional resources from an early age.

Accreditation policies can inadvertently reinforce systemic inequities by upholding Eurocentric definitions of educational quality and performance [17, 27]. Although accreditation is vital in ensuring accountability, its prevailing frameworks often privilege traditional pedagogical models and metrics that marginalize culturally responsive teaching, equity-focused curricula, and Indigenous or decolonizing approaches [28]. Consequently, nursing programs that seek to innovate in these areas risk facing penalties during accreditation reviews. This situation can discourage institutions from pursuing meaningful change, leading them instead to maintain established practices that conform to dominant norms.

The hidden curriculum—used here to describe the implicit norms, values, and ways of being and doing, rather than a formal program of study—plays a significant role in stratifying nursing education. These ways of being and doing often reflect white, middle-class cultural expectations embedded in Eurocentric academic environments. Such unspoken rules shape how professionalism is defined and evaluated, privileging characteristics such as certain speech patterns, appearance, and communication styles [28-30]. They also influence who is perceived as "leadership material" and which behaviors are interpreted as signs of commitment or competence. Students who do not conform to these norms may be mischaracterized as unmotivated, disruptive, or unprofessional.

Additionally, access to informal opportunities—such as research involvement, leadership development, or academic support—is often governed by unwritten rules that disadvantage those who are racially, culturally, or linguistically different from the dominant group. Research highlights how racial microaggressions, exclusion from informal mentoring networks, and differential treatment in clinical and classroom evaluations are ongoing challenges for students and faculty of color [31, 32]. These dynamics reveal how the hidden curriculum reflects and reproduces the inequities in nursing education.

Tension Between "Achievement" and "Access"

One of the most enduring tensions in nursing education is the perceived conflict between "achievement" and "access." Despite the growing awareness of educational disparities, DEIA efforts still face concerns about lowering standards or compromising rigor [33-35], as if excellence and equity are mutually exclusive. This framing reflects a limited view of merit as something that can be objectively measured by grades, test scores, or clinical performance, without considering the context in which these achievements occur. A dichotomy is rooted in meritocratic ideology, which assumes a level playing field and attributes academic success to individual effort rather than systemic advantage [36, 37].

As a result, programs aimed at improving access, such as bridge pathways, mentoring initiatives, and academic support services, are often perceived as remedial rather than essential components of educational equity. Students who rely on these supports may internalize stigma or feel compelled to overcompensate, while prevailing narratives uphold "traditional" success metrics as objective and superior. This framing reinforces the strong hold of meritocratic ideology within higher education, with nursing education reflecting and perpetuating these institutional logics. It assumes a level playing field, ignoring how structural forces like racism, ableism, classism, and language bias shape students' academic trajectories long before they enter nursing school. The burden of navigating this uneven landscape falls most heavily on students and faculty of color, who are often held to higher standards and expected to prove their legitimacy within systems that were never designed with their success in mind [38].

The tension between access and achievement reflects an institutional reluctance to reckon with historical and structural inequities and weakens DEIA efforts by treating equity as a secondary concern. As scholars argue, equity must be embedded into definitions of excellence, rather than positioned in opposition to it [3, 39]. In nursing education leadership, this shift necessitates a redefinition of success—one that prioritizes cultural knowledge, community engagement, and structural analysis alongside academic metrics.

THE MYTH OF MERITOCRACY IN NURISING EDUCATION

The notion of meritocracy—that individuals succeed based on talent, effort, and hard work—remains one of higher education's most enduring and revered ideals [40, 41]. It assumes a level playing field in which success reflects only individual merit and where opportunity is assumed to be equally distributed. Yet as Bonilla-Silva [42] argues, contemporary racial ideology—particularly colorblindness—functions to obscure structural racism while upholding systems of advantage under the guise of fairness. In nursing education, these values are integrated into admissions criteria, academic evaluations, clinical placements, and pathways to advancement. Standards such as GPA, test scores, and professional conduct are frequently portrayed as objective and fair, based on the belief that excellence can be assessed uniformly.

However, critical scholarship increasingly questions this assumption, contending that meritocracy in practice often masks inequity, reproduces privilege, and undermines the objectives of diversity, equity, inclusion, and access [36, 37, 43]. Research in organizational behavior supports these critiques, showing that systems claiming to reward "merit" often reflect and reinforce dominant cultural norms, benefiting those who already hold power while marginalizing others [1]. In contrast, equity-centered models acknowledge that academic and professional outcomes are influenced by systemic factors—including racism, language bias, and access to mentorship—and aim to redefine success in ways that foster justice and

inclusion. In this context, DEIA is not a threat to excellence; it is a necessary corrective to systems that have long conflated privilege with potential.

Meritocracy as a Mask for Inequity

Meritocratic ideology in nursing education assumes that all students enter with similar access to academic preparation, financial stability, cultural capital, and institutional support. In reality, these conditions are deeply influenced by systems of structural inequality. Students from historically marginalized communities often face under-resourced K–12 education systems, financial instability, linguistic marginalization, and social exclusion—barriers that significantly impact their educational trajectories [14, 37]. Yet, when nursing programs rely heavily on GPA, standardized testing, and prerequisite coursework without contextualizing these metrics, they reinforce a narrow and exclusionary definition of readiness and capability [33, 34, 41]. Samson's research [41] reveals that White individuals' commitment to meritocratic standards like GPA is not fixed, but shifts based on perceived group threat—further undermining the idea that merit is a neutral or universally upheld standard. Posselt et al. [44] argue that evaluation and decision-making in academia are not neutral or objective processes, but cultural practices embedded with power and assumptions about legitimacy and merit. Such processes often reward conformity to dominant norms without critical attention while marginalizing equity-oriented excellence.

Moreover, the assumption that success is purely the result of individual effort overlooks the uneven playing field shaped by racism, sexism, and classism. High-achieving students from historically marginalized groups often encounter environments where they are admitted but not fully supported—expected to perform within systems that were not designed with them in mind. McGee and Stovall [45] argue that frameworks like "grit" and "resilience," often applied to students of color, fail to account for the psychological cost of navigating racialized academic spaces. Within nursing, faculty and students of color frequently report being held to higher standards, receiving less mentorship, and facing skepticism about their competence—experiences that cumulatively contribute to racial battle fatigue and professional disenfranchisement [46].

Colorblindness and the Decontextualization of Merit

Another mechanism through which meritocracy operates is colorblindness—the belief that race should not (and does not) factor into decisions around admissions, grading, or advancement. While colorblind ideology is framed as impartial, it often hides deep structural inequities. It overlooks the structural barriers that shape access and success. Nixon [47] asserts that the notion of equal access through higher education ignores how colleges and universities have historically upheld white supremacy, patriarchy, and classism—patterns that persist today. Sweet [15] echoes this, explaining that policies like standardized testing, remedial coursework, and differential advising often perpetuate racialized barriers under the guise of neutrality [15, 47]. Bonilla-Silva [42] argues that colorblindness allows institutions to maintain the status quo while claiming neutrality. In nursing education, this can manifest policies prohibiting race-conscious admissions, curricula that erase the sociopolitical context of health disparities, and evaluative practices that penalize students for culturally grounded communication or behavior [32, 48].

For example, clinical evaluations prioritizing assertiveness or direct communication may disadvantage students whose cultural norms value difference or indirect speech. Faculty may misinterpret culturally influenced expressions of emotion or participation as disengagement or lack of professionalism. These practices reinforce racial and cultural bias and disguise that bias as neutral judgment [29, 30].

Meritocracy and the Hidden Hierarchies of Belonging

Beyond formal evaluations, meritocracy also manifests in informal and hidden ways that shape students' sense of belonging and legitimacy. The perceived notion of "fit"—defined by alignment with dominant cultural norms such as whiteness, English fluency, middle- or upper-class background, and able-bodied—often serves as an unspoken criterion for who is seen as "naturally" suited for nursing. Those who are viewed as fitting these norms are more likely to be afforded trust, informal mentorship, and encouragement toward leadership roles [24, 31, 49]. Conversely, students who do not align with these norms, even when performing at the same academic level as their peers, are frequently perceived as needing to catch up, prove themselves, or adapt their identities to be accepted [50].

This reliance on "fit" reflects what Bhopal [51] calls the "good diversity" narrative—where institutions highlight underrepresented students as success stories while ignoring the structural barriers they had to overcome. In doing so, they reinforce the idea that marginalized students can succeed if they work harder, further entrenching the myth of meritocracy and deflecting responsibility from institutional reform.

Resistance to Equity Through Meritocratic Rhetoric

Meritocracy is also a powerful rhetorical tool used to resist DEIA initiatives. Efforts to implement holistic admissions, diversify curricula, or create inclusive classroom practices are often challenged because they compromise "standards" or prioritize identity over ability. Such critiques, though usually framed as concerns about fairness, rest on the flawed premise that existing metrics of merit are neutral and universally applicable [44, 52]. Lee and Tran [53] demonstrate how references to high-performing racial groups—such as Asian Americans—are strategically used to challenge race-conscious policies, reinforcing the illusion that meritocracy already guarantees fairness for all.

Research shows, however, that negative attitudes toward affirmative action are often shaped less by objective assessments of academic rigor and more by racialized interpretations of merit. Petts [40] argues that public resistance to equity efforts is frequently rooted in perceptions of group threat and racial hierarchy, not principle. As Bonilla-Silva [42] argues, the concept of merit is socially constructed and upheld by dominant groups to maintain existing power structures.

This resistance is particularly evident in responses to race-conscious admissions or faculty hiring. Critics argue that considering race, language, or lived experience violates merit principles. However, this argument fails to recognize how these identities reflect the structural knowledge and cultural fluency essential for serving diverse patient populations and advancing health equity [3]. By rejecting these forms of

expertise, the meritocratic paradigm narrows the field of what counts as excellence and who counts as excellent.

Reframing Merit in Nursing Education

To advance DEIA meaningfully, nursing education must move beyond the myth of meritocracy and toward a more expansive, equity-centered understanding of merit. This involves recognizing that academic and professional success are not solely individual achievements but are influenced by collective structures of opportunity, support, and inclusion. It also requires redefining merit to include cultural humility, linguistic diversity, lived experience, community engagement, and systems thinking—capacities that are increasingly critical in a complex and inequitable healthcare landscape [39, 54].

Equity-minded educators and leaders must be willing to examine their own assumptions about merit, reimagine evaluative practices, and advocate for systemic change. This means resisting the urge to equate rigor with exclusivity and, instead, investing in policies, pedagogies, and leadership development strategies that genuinely level the playing field. Only by dismantling the false neutrality of meritocracy can nursing education fulfill its ethical and professional commitments to equity and social justice.

LEADERSHIP AND ADVANCEMENT IN ACADEMIC NURISING

Leadership in nursing is widely recognized as essential for advancing the profession (education and practice), fostering inclusive learning and working environments, and transforming healthcare systems. Organizations such as the American Nurses Association (ANA), the American Association of Critical-Care Nurses (AACN), and the American Association of Colleges of Nursing (AACN) emphasize that effective nurse leaders are not merely defined by positional authority but by their ability to inspire, influence, collaborate, advocate, mentor, and nurture a culture of compassion, growth, and excellence [55]. Academic nursing leadership, in particular, is seen as a combination of administrative skill, mentorship, advocacy, risk-taking, and transformational guidance—rooted in lifelong learning and service to others [55-57]. These descriptions depict leadership as an accessible, dynamic, and relational practice—one that is not restricted to titles but focused on action and service.

However, while these aspirational definitions reflect the values nursing seeks to uphold, the reality of who is recognized and elevated into leadership roles within nursing education often reflects more restrictive and meritocratic ideals. In practice, leadership is commonly framed as contingent on exemplary performance—defined by adherence to dominant professional norms and alignment with institutional expectations—standards that tend to disproportionately favor individuals who already possess cultural, racial, and social capital within academic institutions [49, 52, 58]. The result is a persistent gap between the inclusive vision of nursing leadership and the exclusionary structures that govern access to it.

Who Gets to Lead? Gatekeeping in Academic Nursing

In academic nursing, leadership encompasses a variety of roles, including positions such as department chairs, deans, department chairs, chairs of committees, and members of governance committees [56]. These positions are often filled through networks of influence, informal sponsorship, and perceived fit with institutional culture, rather than through transparent or equity-minded processes [49, 59, 60]. The criteria for leadership potential often depend on prevailing norms of professionalism, which emphasize attributes typically associated with white, cisgender, able-bodied, and frequently male-coded characteristics like assertiveness, neutrality, and emotional restraint [29, 61, 62].

Faculty from underrepresented backgrounds often face both visible and invisible barriers to advancement. These include lack of mentorship and sponsorship, being overlooked for leadership development opportunities, and experiencing racial or gender bias in faculty evaluations and tenure review [20, 24, 58, 60]. Research shows that women of color, in particular, are disproportionately burdened with service work, expected to serve on diversity committees or mentor marginalized students, often at the expense of their research productivity and career progression [20, 52, 63]. This phenomenon, often called cultural taxation, extracts emotional labor and institutional service without corresponding recognition or reward.

The “Ideal Leader” and Epistemic Exclusion

Leadership norms in academic nursing reflect more than just positional hierarchies; they also embody epistemic standards regarding who is recognized as knowledgeable and what types of scholarship are esteemed. Scholars of color, especially those involved in critical, community-based, or equity-centered research, frequently face epistemic exclusion—being dismissed, marginalized, or devalued because their work diverges from traditional biomedical or quantitative paradigms [32, 64]. Nursing education leadership frequently prioritizes grant-funded research, publications in high-impact journals, and alignment with institutional rankings over community engagement or pedagogical innovation—criteria that systematically disadvantage faculty whose work centers marginalized populations or challenges dominant ideologies.

This devaluation affects promotion and tenure processes. Traditional faculty evaluation rubrics often reinforce dominant norms of merit and fail to recognize equity-focused contributions such as mentoring, community engagement, and inclusive pedagogy [44]. As a result, faculty whose work advances justice or centers marginalized communities often face increased scrutiny or are perceived as less legitimate. Moreover, the very definitions of “excellence” and “impact” are frequently constructed through a Eurocentric lens, with little consideration for cultural relevance or community benefit—criteria that, as Posselt et al. [44] emphasize, are shaped by dominant power structures that often determine who and what is seen as legitimate or meritorious in the academy [25, 39].

Mentorship, Sponsorship, and Unequal Opportunity

Mentorship and sponsorship are critical to leadership development in academic nursing, but access to these resources is far from equitable. Faculty from dominant groups often benefit from informal networks that provide guidance, advocacy, and opportunities for advancement—what Bourdieu [65] describes as social capital. In contrast, faculty of color frequently report navigating their careers in isolation, without the same level of institutional support or visibility [38].

While mentorship is often framed as a one-directional relationship, sponsorship—where senior colleagues actively advocate for mentees in decision-making spaces—is arguably more critical for leadership advancement. Yet, faculty of color are under-sponsored and often expected to prove themselves in ways that white colleagues are not. As Rockquemore [66] notes, underrepresented faculty are routinely evaluated through a lens of presumed deficiency, while white colleagues benefit from presumed competence.

These dynamics not only restrict individual advancement but also influence institutional culture. When leadership remains homogeneous, the perspectives and priorities of those on the margins are excluded from decision-making. This results in a cycle of exclusion that reinforces existing norms and hinders the transformative potential of nursing education.

Meritocratic Narratives and the Resistance to Change

Meritocratic narratives are frequently invoked to justify leadership selection and advancement, often with claims that the best person for the job will rise to the top. However, these assertions ignore the structural conditions that shape access to leadership preparation, visibility, and opportunity [20, 60, 67]. The belief in merit-based leadership advancement legitimizes existing hierarchies and deflects scrutiny of the racialized and gendered dynamics at play [39, 51].

Moreover, when underrepresented faculty attain leadership roles, they often face skepticism, increased scrutiny, or resistance, especially if their leadership style challenges the status quo. Studies show that faculty of color in leadership positions are more likely to experience racialized role strain, particularly when advocating for DEIA-related change [58]. Their presence may be celebrated symbolically, but their power to enact meaningful change is frequently constrained by institutional norms that prioritize tradition over transformation.

Toward Equity-Centered Leadership Models

To challenge these patterns, nursing education must adopt equity-centered leadership models prioritizing relationality, inclusion, and structural change. This includes redefining what leadership looks like and broadening the criteria by which leaders are evaluated. Culturally responsive leadership models, such as transformational, servant, and justice-oriented leadership, offer alternatives to hierarchical, individualistic models rooted in white, Western norms [68].

Remediation and transfer policies, while often positioned as support mechanisms, can function as tools of exclusion. Logue [69] notes that underrepresented students are frequently placed in zero-credit or pre-college courses, denied transfer credits, or funneled into vocational tracks—practices that delay graduation, increase financial burden, and stigmatize these students. As Sweet [15] argues, these practices reflect and reinforce systemic racism within academic structures, particularly when they are not paired with structural reform [15, 69].

Institutions must also invest in leadership development pipelines that prioritize equity and access, deliberately identifying and supporting underrepresented faculty through mentorship, sponsorship, and fair evaluation. These initiatives should not be viewed as optional or remedial but rather as essential to the mission of academic nursing. Without structural changes in how leadership is understood and practiced, DEIA efforts will remain symbolic rather than substantial.

CHALLENGES TO DEIA INITIATIVES

Despite greater attention to Diversity, Equity, Inclusion, and Access (DEIA) in nursing education, significant barriers persist in implementing and sustaining meaningful change. Although institutions often promote their commitment to DEIA through strategic plans, statements, and symbolic gestures, these commitments often fall short of driving transformation. DEIA initiatives are frequently under-resourced, depoliticized, or faced with resistance, especially when they challenge deeply rooted norms or power structures. In the context of U.S. higher education and nursing academia, these challenges are exacerbated by the lasting influence of meritocratic ideology, colorblind policies, and performative equity strategies that obscure deeper systemic issues [14, 52]. At the national level, however, frameworks such as the Boyer Commission's Equity-Excellence Imperative provide a roadmap for transforming rhetoric into institutional responsibility—emphasizing faculty accountability, curriculum reform, and structural change as essential components of equity work [70].

Institutional Resistance Framed as "Neutrality"

One of the most persistent challenges to DEIA work is institutional resistance disguised as neutrality. Administrators and faculty may claim to support equity efforts in principle but argue against race-conscious policies or curricular reforms because they compromise fairness or academic freedom. This resistance often reflects colorblind logic—the belief that institutions should treat all students the same, regardless of race, class, or background. While intended to signal impartiality, such positions ignore the historical and structural inequities that make "equal treatment" insufficient for achieving equity [42].

In nursing education, this type of resistance can appear as a refusal to revise syllabi that focuses on Eurocentric theories, hesitance to adopt holistic admissions policies, or downplaying students' reports of racial bias. Faculty may assert objectivity in grading and clinical evaluations while perpetuating implicit bias and unequal expectations [31]. These forms of passive resistance maintain the status quo while enabling institutions to assert a commitment to inclusion [1].

DEIA as Symbolic and Performative

Many institutions engage in performative DEIA—adopting the language and branding of equity without making substantive or structural changes. This includes creating diversity task forces with no decision-making authority, providing one-time training sessions without follow-up, and celebrating "diverse" individuals without addressing the systemic barriers they encounter [71]. In nursing academia, this may involve highlighting faculty of color in promotional materials while neglecting to support their career advancement or providing culturally competent care modules without critically engaging students on racism or structural inequities in health care [27, 72].

Such performance fosters disillusionment, especially among faculty and students from underrepresented backgrounds who are expected to contribute emotional labor

and institutional service to DEIA efforts without sufficient recognition or compensation [20, 49, 52]. These individuals often navigate a diversity burden—the expectation to fix the institution's inequities while succeeding within it. Research shows that when DEIA is treated as a branding strategy rather than a structural commitment, it leads to performative outcomes, undermines trust, and ultimately harms institutional climate [1].

Political Attacks and Legislative Backlash

In the current U.S. political climate, DEIA work in higher education is facing heightened scrutiny and direct opposition. Recent executive orders and state-level legislation have sought to restrict discussions of race, gender, and systemic oppression in public institutions, framing DEIA as divisive or un-American [1]. These policies create a chilling effect on faculty and administrators, who may fear retaliation or reputational damage for engaging in equity work [14, 73]. As Kuelzer-Eckhout and Houser [2] argue, these gag-order laws and book bans are not isolated acts of censorship—they represent a broader ideological agenda that threatens academic freedom and the democratic purpose of public education itself.

Nursing education programs, particularly those housed within public universities are not immune to this backlash. Faculty have reported pressure to sanitize or depoliticize course content related to racism, health disparities, and historical injustice [2]. DEIA offices are facing funding cuts or restructuring, and initiatives that focus on marginalized voices are being reframed as nonessential. As Ehrlich et al. [73] argue, gag order laws not only censor nursing faculty from addressing racism and health inequities in their curricula—they also threaten institutional accreditation, constrain research agendas, and violate both academic freedom and professional ethics mandates. These laws undermine nursing's capacity to prepare students to address social determinants of health and systemic injustice, weakening the profession's alignment with its codes of ethics and compromising its ability to advance health equity.

Tokenism and the Limits of Representation

While increasing the representation of underrepresented students and faculty is necessary for DEIA work, representation alone does not guarantee equity.

Tokenism—the practice of including individuals from marginalized groups in superficial or symbolic ways—can obscure deeper structural issues. Token individuals are often isolated, hyper-visible, and expected to represent or speak for their entire group, while lacking the power or support to enact change [20, 38, 58].

In nursing academia, tokenism frequently appears when a single faculty member of color is assigned to every DEIA-related initiative, expected to mentor all marginalized students, or called upon to address institutional racism without systemic support. Without intentional retention strategies, workload redistribution, and leadership pathways, these practices lead to burnout, attrition, and the erosion of institutional trust [1, 24, 52].

The Double Bind: DEIA Advocates as "Problematic"

Faculty and students most committed to equity work often find themselves in a double bind—praised for their contributions to DEIA while penalized for being too critical or disruptive. Scholars of color report being labeled as difficult, uncollegial, or agenda-driven when they challenge institutional norms or advocate for anti-racist change [50, 52, 66]. These dynamics create a professional risk for DEIA advocates, who may experience stalled promotions, social exclusion, or retaliation.

This tension is particularly pronounced in tenure and promotion processes, where traditional success metrics (e.g., research funding, publication in high-impact journals) may not value equity-focused work. Faculty who mentor students of color, engage in community-based scholarship, or develop inclusive pedagogy often find that such contributions are viewed as service rather than scholarship, devalued in institutional reward systems [58, 74, 75].

Recognizing and Responding to Resistance

The challenges to DEIA in nursing education are not just logistically, they are deeply ideological and political. They stem from entrenched beliefs about merit, neutrality, and tradition that resist structural change. Addressing these challenges requires more than goodwill or policy statements; it requires institutional courage and a willingness to confront the cultural and systemic forces that maintain inequality.

For DEIA efforts to succeed in nursing academia, institutions must move beyond symbolic gestures and take concrete actions: revise promotion and tenure criteria to value equity work, redistribute labor associated with DEIA, protect academic freedom, and invest in sustainable infrastructure for long-term change. Institutions must recognize that the evidence overwhelmingly supports DEIA as a driver of excellence, not a threat to it [25]. Decades of organizational research, including recent findings, affirm that DEIA genuinely and strategically contributes to innovation, belonging, and institutional effectiveness when implemented [1]. Without these steps, DEIA will remain an aspiration rather than a reality—and the myth of meritocracy will continue to obscure the need for structural transformation.

REFRAMING SUCCESS – TOWARD EQUITY-CENTERED PRACTICES

In the face of growing resistance to Diversity, Equity, Inclusion, and Access in U.S. higher education, nursing education and leadership must resist the pull toward neutrality and instead embrace a bold, equity-centered redefinition of success. The current moment demands more than incremental change or symbolic gestures; it requires dismantling deeply rooted meritocratic ideals and reimagining educational values, systems, and practices.

Recent research affirms that DEIA is morally imperative and instrumental to institutional excellence, enhancing belonging, innovation, and long-term performance when implemented with integrity and commitment [1]. National reform efforts reflect this shift: the Boyer Commission [70] urges universities to reject the false dichotomy between equity and excellence and to incorporate inclusive, equity-oriented practices into core academics values. Despite attempts to discredit DEIA, the evidence overwhelmingly supports its positive impact on workplace effectiveness, representation, and climate across sectors. Given the profession's stated commitment to social justice, human dignity, and health equity, academic nursing

Table 2. Contrasting traditional and equity-centered leadership models in academic nursing

Leadership characteristic	Traditional model	Equity-centered model
Criteria for advancement	Research productivity, grant funding, alignment with status quo	Equity impact, inclusive pedagogy, mentorship, community engagement
Leadership style	Hierarchical, individualistic, formal	Relational, collaborative, justice-driven
View of DEIA work	Peripheral or categorized as service	Central to professional excellence and institutional mission
Mentorship & sponsorship	Informal, often within dominant networks	Intentional, transparent, aimed at lifting underrepresented colleagues
Definition of "excellence"	Based on dominant metrics (impact factor, rank, institutional fit)	Contextual, inclusive of lived experience, culturally grounded, and systems-oriented
Approach to change	Maintains stability; avoids conflict	Embraces discomfort; challenges inequity; seeks systemic transformation

Source: Adapted from [1, 32, 44, 52, 68]

must lead in challenging exclusionary norms and advancing transformative inclusion [76].

Rethinking What Counts as "Merit"

The myth of meritocracy continues to influence how success is defined and rewarded in nursing education—from student admissions and performance evaluations to faculty promotions and leadership selections. As earlier sections of this paper have demonstrated, traditional metrics (e.g., GPA, standardized tests, grant funding, impact factors) are frequently presented as objective and neutral; however, they favor those with pre-existing access to power, resources, and dominant cultural capital [37, 52]. Recent political narratives have portrayed DEIA initiatives as unnecessary, divisive, or harmful to institutional excellence. However, these assertions lack empirical support. In fact, decades of research highlight the advantages of DEIA for organizational performance, equity, and innovation [1].

An equity-centered approach challenges institutions to redefine merit in ways that account for context, lived experience, and structural barriers [25]. This includes recognizing cultural humility, linguistic diversity, community engagement, and DEIA-focused scholarship as forms of academic excellence. Public health literature has long affirmed that addressing health inequities requires a diverse, equity-conscious workforce — a reality that begins with educational environments and leadership structures [76].

Embedding Equity into Evaluation and Accountability

To reframe success, institutions must embed equity into the structures that define achievement. This includes revising admissions processes to ensure holistic review, restructuring student assessments, and shifting faculty development to support equity-minded practice — where practitioners take responsibility for the equity implications of their actions and outcomes [36, 77]. Evidence from academic nursing highlights how institutions that adopt DEIA scorecards or embed equity-minded faculty evaluation practices begin to close gaps in recruitment, retention, and leadership advancement. For example, Institutions like the University of Southern California and Portland State University have begun implementing equity scorecards and equity-minded rubrics to guide hiring, teaching, and evaluation — models that nursing education can adapt and build upon [74].

In nursing leadership, this also means challenging assumptions that professional success is consistently demonstrated through dominant cultural behaviors or hierarchies. The continued undervaluing of faculty members who engage in community-embedded work or critical pedagogy reflects a failure of imagination and an institutional bias against equity-focused innovation [32]. In faculty promotion and tenure, equity-centered evaluation might include recognition of mentoring and advocacy work, inclusive pedagogy, or research that addresses racial disparities and social determinants of health. As Posselt et al. [44] argue, equitable decision-making requires expanding the definitions of merit to include contributions often undervalued in dominant evaluation cultures. These practices signal to faculty that institutional values are not confined to narrow, prestige-based metrics but are aligned with justice, accountability, and inclusion.

Leadership Models That Disrupt the Status Quo

Redefining success also means reimagining leadership to prioritize relationality, courage, and coalition-building over individualism and conformity. As previously discussed, traditional leadership models in academic nursing often reward those who maintain existing structures rather than those who challenge them. By contrast, equity-centered leadership embraces transformational, servant, and critical leadership approaches—models grounded in ethical responsibility, collective empowerment, and systemic change. In alignment with this vision, the American Public Health Association [68] advocates for community-centered leadership, explicitly antiracist, and rooted in power-sharing and accountability. These principles align with nursing's core social justice and health equity commitments and call on nurse educators to lead beyond institutional preservation. **Table 2** outlines key distinctions between traditional and equity-centered leadership paradigms.

William et al. [25] emphasize that faculty of color who lead equity work often do so under significant institutional strain, navigating racism, marginalization, and overwork while attempting to shift culture and policy. Yet these leaders also model equity-centered leadership—courageous, collaborative, and future-facing. Such leadership aligns with research affirming that equity-oriented leadership contributes to a stronger institutional climate, employee engagement, and innovation across disciplines [1]. Supporting them through protected time, leadership pipelines, and material resources is essential for retention and systemic transformation.

This shift calls for rethinking leadership pipelines, ensuring that underrepresented faculty are included, meaningfully supported, sponsored, and prepared for roles of influence. Succession planning should center equity goals, not just institutional continuity, and leadership development programs must interrogate the values they transmit. In line with this shift, national reports like the Boyer Commission [70] stress that institutions must embed equity into faculty reward systems—treating inclusive teaching, mentoring, and

antiracist leadership not as service, but as excellence. As defined by Nishii and Leroy [78], inclusive leadership operates across individual, team, and institutional levels—embedding belonging, fairness, and psychological safety into an organization's culture.

Arif et al. [79], writing from the perspective of pharmacy education, similarly argue that DEIA must be integrated not just into mission statements, but into leadership practice, curricular reform, and continuing professional development. This includes fostering critical reflection, identifying systemic barriers, and operationalizing equity through action-oriented policies. Adopting this multi-level, action-driven approach in nursing education would support systemic inclusion rather than relying solely on individual leaders to shoulder equity work. Without intentional leadership development that disrupts dominant norms and reimagines institutional values, nursing academia will continue reproducing the inequities DEIA seeks to dismantle.

Learning Environments that Affirm and Empower

Equity-centered practices must also reshape the learning environment. Moving beyond surface-level inclusion requires critical pedagogies that explicitly address race, power, and social determinants of health [1]. In a climate where such conversations are being legislatively restricted, academic nursing must assert its responsibility to prepare socially conscious nurses by creating brave spaces for dialogue, reflection, and resistance [32, 80, 81]. Nursing faculty and leadership must assert the importance of academic freedom and prepare students to understand—and challenge—the structural drivers of health inequity.

This means integrating anti-racist frameworks, decolonial scholarship, and culturally sustaining teaching into nursing curricula—not as supplemental content, but as foundational. Faculty should be supported to develop brave learning spaces where students can critically engage with how systems of oppression intersect with health, policy, and professional practice [32, 72]. As the National Academies' report makes clear, health equity begins in the classroom, where future nurses learn what it means to care not just for individuals, but for justice [76].

Building Institutional Will and Infrastructure

Reframing success requires not only new ideas but also institutional will and material infrastructure. DEIA efforts cannot be sustained through isolated workshops or one-time funding initiatives. Institutions must commit to long-term funding for equity-oriented research, support affinity and identity-based faculty and staff groups and integrate DEIA into strategic plans with measurable outcomes [82].

In politically hostile environments where DEIA is being legislated out of existence, institutional leaders must be prepared to practice "equity under siege"—finding alternative language, building coalitions, and protecting the intellectual work of students and faculty committed to justice. Efforts to undermine or defund DEIA are not evidence-based—they are ideological, driven by resistance to systemic change rather than concern for educational quality [1]. Moreover, institutions must defend academic freedom and institutional autonomy in the face of political interference. Equity cannot be an optional or politically convenient pursuit. It is, as the ANA [8] affirms, central to the ethical mandate of the nursing profession.

CONCLUSION: FROM MERIT TO JUSTICE

Reframing success in nursing education is not a theoretical exercise, it is an urgent act of resistance and professional responsibility when DEIA is under political attack. As legislative efforts seek to dismantle equity work under the guise of neutrality and merit, academic nursing must respond not with retreat, but with resolve. This moment demands a bold, unapologetic commitment to justice that challenges entrenched systems, redefines excellence, and builds inclusive structures that nurture all learners and leaders.

If nursing is to honor its core values of advocacy, compassion, and equity, academic institutions must reject the myth that merit alone determines success. Instead, they must embrace an equity-centered vision that values lived experience, community-rooted scholarship, and systemic transformation. In resisting these attacks, nursing education must defend its ethical mandate and its role in preserving the democratic values of public education and critical inquiry [2].

Reframing success is both a political and moral imperative. It requires reimagining not only what we reward but also who we recognize, support, and empower. The data are clear: when equity is embedded into institutional structures, it does not diminish excellence—it defines it [1]. The future of nursing—and the health of the communities it serves—depends on our willingness to lead with justice.

Author contributions: KI: originated the manuscript idea, led the development of the argument, and drafted the initial version. **KIA**, **RCJ, JNI, & VEM:** contributed to shaping the intellectual content, refining the structure, and strengthening the critical analysis. All authors reviewed, revised, and approved the final manuscript. All authors have agreed with the results and conclusions.

Funding: The authors received no financial support for this research, authorship, or article publication.

Ethical statement: The authors stated that this study is a secondary analysis of publicly available published reports that does not require the participants' ethical approval or informed consent.

AI statement: The authors stated that AI tool (aiAI) is used only for grammar, spelling, and punctuation checks. No ideas, content, or citations were generated by AI. The authors reviewed all suggestions and take full responsibility for the final work.

Declaration of interest: The authors declare that they have no competing interests.

Data sharing statement: Data supporting the findings and conclusions are available upon request from the corresponding author.

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