The Experiences of Clinical Placement Belonging Among Nursing Students with Racially and Ethnically Minoritized Identities: An Interpretive Descriptive Study

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Nursing

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Abstract

**Background:** Within clinical learning environments, a students’ sense of belonging has been identified as a pre-requisite for effective learning. Unfortunately, many aspects of nursing education act as barriers to belongingness among students with racially and ethnically minoritized identities. Although prejudice and discrimination represent barriers to belongingness, there is a paucity of literature exploring how racially and ethnically minoritized nursing students experience belonging during their clinical placements.

**Aim:** To explore how nursing students with racially and ethnically minoritized identities experience a sense of belonging during their clinical placements.

**Research Design:** The researcher followed an interpretive descriptive design informed by intersectional theoretical perspectives. Qualitative thematic analysis was used to analyze the interview data.

**Findings:** The study identified five themes: (1) Belonging as a Determinant to Student Learning, Retention and Patient Safety; (2) Minoritized Identities on Display: Discrimination Threatening Clinical Belonging; (3) How Power Dynamics at the Interpersonal and Institutional Levels Silence Students from Addressing Discrimination in the Clinical Environment; (4) “We Take it Seriously”: How the Representation of Minoritized Identities Influences Students’ Sense of Belonging; and (5) How Nursing Students’ Identities Intersected to Influence their Experiences of Belonging During Clinical Placements.

**Conclusion:** Findings highlight the importance of dismantling discriminatory structures within nursing education and practice and of investing in strategies to improve student belonging. Strategies to improve belonging need to be comprehensive by targeting the numerous factors that influence belonging experiences. Ultimately, improving racially and ethnically minoritized students’ clinical placement sense of belonging has positive
implications for student learning, patient safety, and for retaining a diverse nursing workforce.

Keywords

Sense of Belonging, Nursing Students, Nursing Education, Baccalaureates, Clinical Education, Clinical Placement, Minoritized, Race, Ethnicity, Intersectionality
Summary for Lay Audience

To become effective nursing professionals, nursing students are often provided with learning opportunities within the hospital known as clinical placements. For nursing students to learn effectively during these clinical placements, it is important for them to feel like they belong within the hospital learning environment. Unfortunately, nursing students with racially or ethnically minoritized identities often experience discrimination during their clinical placements that negatively impacts their sense of belonging. Although discrimination can negatively impact nursing students’ sense of belonging during clinical placements, the experiences of racial and ethnic minoritized students have been overlooked in nursing studies on sense of belonging. Based on this research gap, the main purpose of this study is to gain an understanding of how students who self-identify as a member of a racially or ethnically minoritized group experience a sense of belonging during their clinical placements.

Throughout this study, the researcher spoke with nursing students who self-identify as a member of a racial or ethnic minoritized group to learn more about these students’ experiences of belonging within the clinical environment. The study considered how participants unique identities and power relationships impacted these experiences which uncovered five themes: (1) belonging is integral to patient safety, student learning, and student retention in higher education, (2) discrimination negatively influences sense of belonging, (3) institutional barriers and power dynamics hinder students from addressing and/or disclosing their experiences of discrimination, (4) the representation of other racially or ethnically minoritized individuals in the clinical space influences experiences of belonging, and (5) aspects of participants identities (i.e., race and gender) intersect to inform how participants experience belonging in the clinical setting. These findings speak to the
importance of addressing discrimination within nursing education and practice and of investing in strategies to improve student belonging. Strategies to address barriers to student belonging need to be comprehensive in their approach by targeting the personal, interpersonal, community, organizational and policy level factors that contribute to their prevalence. Ultimately, improving racially and ethnically minoritized students’ sense of belonging during their clinical placements has positive implications for student learning, patient safety, and for retaining a diverse nursing workforce.
Co-Authorship Statement

Connor Gould completed this work under the supervision of Dr. Susana Caxaj (thesis supervisor) and Dr. Saleema Allana (committee member) who will be co-authors of the resulting publications and presentations produced from this work.
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Chapter 1: Introduction

1.1 Introduction / Research Questions

In nursing academia, clinical learning opportunities are crucial in supporting students’ academic and professional development. By combining classroom theory with real-life practice, clinical experiences allow students to develop the knowledge, confidence, skills, and behaviors required to become effective nursing professionals (Flott & Linden, 2016; RNAO, 2017). Through research in clinical education, nursing students’ sense of belonging in the clinical environment has been recognized as a necessary precursor to effective clinical learning (Kim & Jung, 2012; Levett-Jones & Lathlean, 2008). Unfortunately, nursing students with racially and ethnically minoritized identities may encounter discrimination and prejudice in many facets of nursing academia that act as systemic barriers to belongingness during clinical placements (Metzger et al., 2020; Sedgwick et al., 2014). Despite the negative impact of discrimination on nursing students’ sense of belonging (Metzger et al., 2020; Sedgwick et al., 2014), a dearth of timely Canadian literature exists exploring how this population experiences belonging during clinical placements. Additionally, missing from the belonging body of literature is research that problematizes the privilege of Whiteness in the profession, and recognizes the intersectional nature of students’ experiences of belonging. As a result, there is a limited understanding of how power dynamics and students’ intersectional identities shape these experiences. To address these gaps in the literature, the researcher conducted an interpretive descriptive study informed by intersectional theoretical perspectives to explore how nursing students who self-identify as having a racially or ethnically
minoritized identity experience a sense of belonging during clinical placements. The primary research question that guided this qualitative study was:

- What are the experiences of belonging during clinical placements among nursing students with racially and ethnically minoritized identities in mid-sized Ontario cities?

The secondary research questions that guided the study included:

- How do systems of power influence sense of belonging during clinical placements among nursing students with racially and ethnically minoritized identities?
- What are the factors that influence sense of belonging during clinical placements among nursing students with racially and ethnically minoritized identities?

1.2 Use of Terminology

When using categories or collective terms to describe race and ethnicity, it is important to ensure that the language being used supports diversity and conveys respect. For example, use of the word ‘minority’ to describe particular racial or ethnic groups is generally considered inappropriate because it carries a connotation of hierarchy between groups (Flanagin et al., 2021), and may not accurately reflect who is considered the ‘majority people’ within a certain community. To avoid using stigmatizing language, the researcher chose to use the term nursing students with racially or ethnically minoritized identities. Using the term minoritized acknowledges that individuals do not naturally exist as a minority; Rather, using the term minoritized recognizes that oppression and inequality actively shape the social processes that position individuals as minorities.
(Milner & Jumbe, 2020; Sotto-Santiago, 2019). When using the term minoritized as an adjective, it is important to include the noun it is describing to increase the specificity of the term (Flanagin et al., 2021). Moreover, use of the word ‘identities’ avoids essentializing racial and ethnic groups by acknowledging that a diversity of racial and ethnic identities exists. Thus, use of the term ‘nursing students with racially and ethnically minoritized identities’ was deemed to be best suited to acknowledge participant diversity and convey respect. For the purpose of the research, nursing students with racially and ethnically minoritized identities (NSREM), referred to individuals that are subject to marginalization and oppression based on their self-identified cultural identity (such as language, religion, or traditions) and/or personal characteristics (such as skin, hair, or eye color).

1.3 Background

A nursing students’ sense of belonging may be influenced by their own personal characteristics, the relationships they have with staff, patients, and their families, and the clinical placement environment (Sedgwick & Rougeau, 2010). Positive feelings reported by nursing students who experience belonging during clinical placements include comfort, satisfaction, happiness, and safety (Levett-Jones & Lathlean, 2008). As a result of feeling recognized and accepted as a member of the nursing team, students feel more empowered to make the most of available learning opportunities, feel self-assured in their ability to enhance their learning by asking questions, and direct more of their focus on learning instead of trying to fit in (Levett-Jones & Lathlean, 2008). Additionally, previous literature suggests that belongingness may promote the retention of nursing students in higher education (Borrott et al., 2016). In contrast, the consequences of a lack
of belonging are multi-faceted. Students who feel alienated may experience increased stress and anxiety, poor job satisfaction in their role as a student, a decreased willingness to learn, and may experience a wide range of negative emotional, behavioral, or psychological consequences (Borrott et al., 2016; Levett-Jones et al., 2007a).

In response to Toronto Public Health declaring anti-black racism a public health crisis (City of Toronto, 2020), numerous Canadian nursing organizations collectively acknowledged the history of discrimination within nursing academia, as well as the impact that current day systemic racism has on the success of racialized individuals within the profession (Canadian Nursing Association, 2021). Nursing academia is repeatedly characterized as isolating, discriminatory, and unsupportive to NSREM (Beagan et al., 2022; Bell, 2020, Waddell-Henowitch et al., 2022). In a recent review focused on racism and white privilege in nursing academia, nursing curricula were found to often sustain problematic ideologies such as Whiteness and classism that contribute to feelings of difference and othering among NSREM (Bell, 2020). As nursing educators often lack the appropriate competency to address racism and privilege, problematic ideologies are generally undeterred and are subsequently reproduced in future nursing professionals (Bell, 2020). During clinical experiences, discrimination towards NSREM may come from faculty, clinicians, or peers, and can be enacted in ways that directly limit learning opportunities (Metzger et al., 2020). Discrimination may be based on skin colour, ethnic differences, and language fluency. The consequence for students who experience discrimination is feelings of isolation, loneliness, and a lack of belonging (Koch et al., 2015; Metzger et al., 2020; Sedgwick et al., 2014).
1.4 Purpose Statement

The purpose of this thesis is to explore how NSREM experience belonging during their clinical placements. The objectives of this thesis are to: (a) describe how systems of power influence these students’ experience of belonging, (b) and to identify the factors that influence these students’ experiences of belonging. To meet these aims, the researcher has utilized a qualitative interpretive descriptive study informed by intersectional theoretical perspectives.

1.5 A Personal Reflexive Narrative

I am a Canadian-born individual of German, English, and Irish descent. This identity is informed by where my ancestors originated from before settling in Canada. On my father’s side, my grandmother was born in what was formally known as the Free City of Danzig (now known as Gdansk, Poland). During the occupation of Danzig by the Soviet Union following World War 2, my grandmother and her family were forced to flee west to England where my grandmother met my grandfather. After giving birth to my father, my grandparents settled in Ontario in the 1960s because it was closer to other family members that had already moved to Canada. On my mother’s side, my grandparents were born in Canada after my great grandparents migrated from Ireland and England. As previous generations of my family settled in a land inhabited by Indigenous peoples, I recognize that I am of settler ancestry. I currently live in a mid-sized city in Southwestern Ontario that is situated on the traditional territories of the Attawandaron, Anishinaabeg, Haudenosaunee, and Chonnonton peoples. I recognize that I hold numerous privileges due to many of my many intersecting social locations including my
Whiteness, male gender, middle-class background, heterosexuality, and as a person without a disability.

As a white individual, I am dedicated to continually interrogate my own motivations in doing work with racialized individuals to ensure these motivations are not rooted in personal validation or in fulfilling a white savior narrative. Given my social location as a white researcher, I have turned towards Richard Milner’s (2007) framework on researcher positionality to guide me in doing this work. Milner (2007) describes that if researchers do not reflect on their own cultural ways of knowing and positionality, this can increase the risk that the researcher misinterprets or misrepresents the individuals that they work with throughout the research process. One aspect of Milner’s (2007) framework encourages researchers to reflect on questions such as “In what ways do my racial and cultural backgrounds influence how I evaluate and interpret the experiences of others?” As a white male, I occupy a position of unearned privilege. The dangers in doing this work from this position of privilege is that my cultural lens limits my awareness of racialized epistemologies. This lack of awareness amplifies the risk that I misrepresent the realities of racialized individual’s lived experiences. Instead of assuming that I know what is best for others, I recognize that participants are experts on their own experiences. Throughout this work, I sought to center the voices and experiences of participants. To attempt to amplify their voices, and respect their agency and self-determination, I encouraged participants to critique the research methods, and asked them to provide recommendations about actions they believe are required by relevant decision-makers based on their experience. In alignment with multiple aspects of Milner’s (2007) framework, this feedback from participants ultimately informed the recommendations for
action provided in the discussion section to ensure that participants voices are represented in the findings of the study, and to attempt to avoid prioritizing my own interests over those who are participating in the research.

Despite the risks noted above in me as a white researcher doing this work, there are also risks when racialized individuals are the only ones engaged in efforts towards dismantling systems of oppression. Arif and colleagues (2022) use the term “cultural taxation” to refer to the extra work racialized individuals often endure in carrying out equity, diversity and inclusion initiatives that may limit their career advancement because their efforts in doing this work may often go unrecognized. Arif and colleagues (2022) also highlight that because faculty and staff in higher education may predominantly members of the dominant culture, that allyship is crucial to amplify equity, diversity, and inclusion initiatives and share the workload associated with these initiatives. Part of the impetus for me in doing this work is the recognition that every individual shares responsibility in addressing societal inequities. Given my limitations in doing this work as a white researcher, and the potential harm I may cause, I approach this work from a place of humility. This involves engaging in strategies for authentic allyship such as actively listening to, and respecting the feedback of participants, seeking to learn more by engaging with the literature, and working withing faculty committees dedicated to supporting racialized students to better understand the support these students feel they may need (Arif et al, 2022).

I have practiced nursing for five years, and have four years of teaching experience, teaching both nursing students and graduate students in clinical and classroom settings. My interest in choosing nursing as a career option stemmed from my
personal experiences caring for my grandmother. Before she passed, my grandmother suffered from late-stage vascular dementia, requiring her to live with myself and my parents. In caring for my grandmother, I realized that caring for others brought me personal satisfaction and sought nursing as a viable option to pursue this passion. Having worked as a nurse now for five years, my experiences caring for a diverse community of patients have informed my commitment to address the structural factors that negatively shape experiences and health outcomes. I have witnessed how influences such as racism and discrimination can stigmatize and harm groups of people to produce inequitable outcomes. By occupying a position as a nursing researcher and educator, I view it as my personal responsibility to actively oppose oppressive structures within society to support health equity and see research as an effective means of informing transformative action.

My interest in conducting belonging research developed through my own personal experiences as a former nursing student and clinical instructor. Throughout my undergraduate clinical education, many individuals involved in my learning were welcoming and sought to involve me as a meaningful member of the healthcare team. These welcoming and supportive environments made me excited to attend clinical placements, made me feel as though I belonged as a member of the healthcare team, and created a space in which I was comfortable to learn and make mistakes. Conversely, I also experienced clinical environments where nurses made it clear through their language or tone that they found my presence burdensome. Some nurses often made minimal effort to involve me in patient care and made negative comments about students’ level of competency. As a male student in a female dominated profession, I was also subject to comments about my gender during my clinical placements that made me question my
ability to belong in the nursing profession. For example, comments such as “men can’t provide care in a way that women can” made me question my own competency in the role and whether I was well suited to work as a nursing professional. These unwelcoming behaviors made me question whether I belonged in the clinical environment, and negatively impacted the self-confidence I needed in order to seek out learning opportunities in this space. As my career progressed, I eventually became a nursing educator within the clinical space. Consistent with my own experience as a student, I observed that when students were subject to non-welcoming behaviors, they became largely disengaged from the learning process. Drawing from these experiences, I see belongingness within the clinical environment as integral to student learning and self-concept. My goal in conducting research in student belonging is to produce knowledge that can be used to create an academic environment where all students feel as though they belong and are supported in their learning needs and well-being. My specific choice of research topic is informed by my recognition of the impact of racism and discrimination on student’s experiences of belonging. I chose to work with this population to raise awareness of the experiences of belonging among students who are frequently marginalized due to aspects of their identity within nursing academia and clinical practice. In doing so, I hope that the knowledge produced by this thesis can be used to inform strategies to foster belonging within the clinical environment and address structural inequities.

My personal experiences and social locations inform my insider/outsider relationship with the participants in this study. As a white privileged researcher studying nursing students with racially or ethnically minoritized identities, I recognize that my
race and ethnicity position me as an outsider. While conducting the study, I was wary that my outsider status may limit my ability to appropriately understand participant’s experiences, to conceptualize questions that are relevant to their unique intersectional experiences of belonging, or to create a trusting environment in which participants are comfortable sharing their experiences. Throughout the research, I strived to remain cognisant of my outsider status, and recognized that I do not speak for participants. Instead, I sought to accurately represent what participants told me to promote a deeper understanding of their experiences within nursing education. Conversely, my prior lived experience as an undergraduate nursing student navigating feelings of belonging within the clinical environment positions me as an insider. This lived experience informed my understanding of the context of clinical education that supported my understanding of participants’ nuanced experiences of belonging. Because of this insider position, I was aware that I needed to reflect upon how aspects of my own lived experience with belonging can inform and also contrast with the experiences that shared by participants.

As a novice researcher, many of the beliefs I bring into the research process align with many of the common values of other critical researchers as summarized by Carspecken (1996). These beliefs include:

1) That research should be used to critique, challenge, and change unfair aspects of contemporary society.

2) That privilege and inequality exist and should be opposed within society.

3) That privilege and inequality are most likely to be reproduced when the forces of oppression remain unchallenged.
3) That many forms of oppression exist, and researchers should avoid focusing on only one form of oppression if it means ignoring others.

5) That mainstream research is often complicit in reproducing oppression. Thus, critical researchers must support different research principles than mainstream research to avoid reproducing oppression.

As I plan to continue to pursue a career in nursing education, I have sought opportunities to espouse these values. For example, I have been studying and practicing inclusive pedagogies in response to the troubling history and ongoing systemic discrimination and oppression present within Canadian society and academia. I was recently employed as a Teaching Assistant Training Program Instructor through Western University’s Centre for Teaching and Learning. Within this role, I lead workshops with a group of inter-disciplinary teaching assistants who wish to improve their lesson designs. Within these sessions, I frequently advocate for inclusive pedagogies such as avoiding the use of colloquialisms, ensuring that lessons represent knowledge from diverse perspectives, and suggest participants provide multiple forms of student engagement to ensure that all students have the opportunity to participate in the co-creation of knowledge. Finally, I am also the graduate student representative for the Decolonization/Anti-Racism/Anti-Oppression Committee through Western University’s School of Nursing. Within this role, I collaborate with faculty and students in ongoing efforts to address the intersecting forms of oppression that perpetuate inequities in nursing education. In choosing to explore the experiences of belonging among students who identify as having racially and ethnically minoritized identities, I saw an opportunity to continue to enact the principles and values of a critical researcher. In alignment with
this value orientation, I believe racism and discrimination to be systemic barriers to belonging that should be actively challenged. In recognition of the many faces of oppression, I explored belonging using an intersectional lens to develop a more nuanced understanding of the experiences of belonging within the clinical environment. By aligning the research with my value orientation, I hope to assist current initiatives to promote belonging and inform anti-racist and anti-oppressive efforts within Canadian Schools of Nursing.

1.6 Overview of the Thesis

In this chapter, the purpose and research questions guiding the research were identified. In chapter two, a review of the literature provides further context to the purpose and significance of the research and highlights a gap in the belonging literature. In chapter three, the methodological underpinnings of the research are discussed. Finally, in chapter four, the results, discussion, and recommendations from the study are illustrated.
1.7 References


2 Chapter Two: Literature Review

To provide additional context to the research topic, this chapter begins with a literature review. Firstly, I provide some insight into my approach to the literature review. I then highlight how the term sense of belonging has historically been conceptualized and theorized in the literature. This section provides context to how belonging was defined for the purpose of the research. I then review the existing literature on belonging and discrimination within the broader context of higher education. In doing so, I review the research findings on the impact of belonging on students’ academic success and mental well-being and provide insight into the structural barriers racialized students may face that negatively influence their sense of belonging when navigating academia. After this, I review the literature on discrimination within Canadian academia, before exploring it within the specific context of Canadian nursing education to provide further context to the systemic discrimination present within the setting of the study. Finally, I review the existing belonging literature within the context of the study (i.e., nursing clinical placements) and highlight gaps found within this body of literature.

2.1 Literature Search

I identified a need to conduct this research after conducting a literature review guided by two questions: “what is the current state of knowledge on baccalaureate nursing students’ belongingness during clinical placements?” and “what evidence exists regarding the influence of race and ethnicity on baccalaureate nursing students’ belongingness during clinical placements?”. Articles had to have an available full text, written in English, with belonging and nursing clinical education as the main topic of focus to be included in the review. Search terms included, but were not limited to
‘racism’, ‘discrimination’ and ‘ethnicity’. Following this initial search, I expanded my
search to develop a more holistic understand of belonging as it relates to my research
questions. This included understanding how belonging has historically been
conceptualized, developing an understanding of belonging within the context of higher
education and nursing, and finally, developing an understanding of the culture of
systemic discrimination within Canadian academia and nursing education.

2.2 Defining Sense of Belonging

Sense of belonging is a broad concept that has been studied across a wide variety
of disciplines. Studies exploring a sense of belonging approach the concept from a variety
of theoretical and empirical perspectives that have led to inconsistencies in the way the
term has been measured and conceptualized (Allen et al., 2021). Yet, some overlap in
definitions does exist. For example, some definitions of belonging include identifying
with a shared history and values as well as group membership (Hagerty et al., 1992;
Levett-Jones & Lathlean, 2008; Mahar et al., 2013). These definitions align with aspects
of Chavis and McMillan’s (1986) conceptualization of sense of community.

Although definitions of sense of belonging within the literature can often be
inconsistently defined, or not present at all, many contain recurring themes (Caxaj & Gill,
2016; Mahar et al., 2013; Vivekananda-Schmidt & Sandars, 2018). For example, in a
scoping review by Vivekananda-Schmidt and Sandars (2018) exploring how
belongingness has been conceptualized across both the higher education and health
professions education literature, all definitions of belonging involved personal feelings of
connection or acceptance from others. Similarly, Hagerty et al.’s (1992) concept analysis proposed that an individual experience of being valued or needed, by an external referent (the physical, social, or spiritual environments, objects, persons, or organizations to which one feels they belong) was a defining attribute of belonging. Secondly, there is a large degree of agreement within the literature that belonging is a fundamental human need that is required by all people (Allen et al., 2021; Baumeister & Leary, 1995; Hirsch, & Clark, 2019; Levett-Jones et al., 2007; Maslow, 1968; Maslow, 1943; Schlossberg, 1989; Strayhorn, 2019). It is also suggested that an individual’s desire to belong is capable of influencing human behavior (Allen et al., 2021; Strayhorn, 2019). These behaviors can be either productive (i.e., seeking interpersonal connections) or detrimental (i.e., using bullying to attempt to gain acceptance from peers) (Allen et al., 2021; Strayhorn, 2019). Engaging in negative behaviors in the hopes of belonging is also supported within the nursing literature. In order to improve their chances of belonging, nursing students in their clinical placements described conforming to nursing practices that they knew to be incorrect (Levett-Jones & Lathlean, 2009b), and neglected to speak up when they believed their patient’s condition was deteriorating (Honda et al., 2016).

In an attempt to bring together disparate views of belonging to find a definition that transcends disciplines, Mahar and colleagues (2013) conducted a narrative review of the belonging literature. Mahar and colleagues (2013) identified that most definitions of belonging involved feelings of being needed, important, valued, integral to, and respected by a group or system, which is consistent with findings from other reviews of the literature (Hagerty et al., 1992; Vivekananda-Schmidt & Sandars, 2018). Mahar and colleagues (2013) also highlighted five elements that were deemed essential to any
formal definition of sense of belonging including subjectivity, groundedness, reciprocity, dynamism, and self-determination. This review will elaborate upon each of the elements of belonging identified by Mahar and colleagues (2013), as many of these elements are consistent with work by other scholars (Allen et al., 2021; Levett-Jones & Lathlean, 2008; Strayhorn, 2019).

In the theme titled subjectivity, Mahar and colleagues (2013) report that a sense of belonging centers on individual perceptions of feeling value, respect, or engagement within a group. In addition, Mahar and colleagues (2013) recognize earlier works by Hagerty and colleagues (1992) as well as Hurtado and Carter (1997) who suggest that an individual’s perceptions of belonging are separate from one’s objective membership within a group. Hagerty and colleagues (1992) highlighted that belonging has different meanings when viewed from physical, spiritual, sociological, and psychological perspectives. They identified that from a physical perspective, belonging refers to the possession of tangible persons, objects, or places. From a spiritual perspective, belonging refers to an individual’s relationship with a transcendent being or place. From a psychological perspective, belonging refers to an individual’s personal experience of feeling belonging towards a particular group such as feelings of being valued or respected. This psychological perspective of belonging is often referred to as a ‘sense of belonging’. Finally, from a sociological perspective, belonging refers to an individual’s membership within a particular group or system. This sociological perspective includes the recognizable actions that connote belonging to a group such as participation, formal membership, and proximity within that group. Providing distinction between the psychological and sociological perspectives is important because although an individual
may engage in actions that connote belonging to a group, they may not experience a sense of belonging within that group. Thus, any definition of sense of belonging must recognize an individual’s subjective perception of belonging separate from their objective membership in a group, as these perceptions highlight how belonging to the group makes the individual feel (Mahar et al., 2013).

The second theme, groundedness, stemmed from findings that many definitions of belonging specified a system or group that one believes they belong to (Mahar et al., 2013). In order to understand belonging, a group, person, or system must exist that can act to anchor the individual’s subjective perceptions of belonging (Mahar et al., 2013). For example, Hausmann and colleagues (2007) define sense of belonging “as the psychological sense that one is a valued member of the college community”, thereby highlighting that the college community is the group to which an individual feels a sense of belonging. Thus, to understand an individual’s subjective feeling of belonging requires the identification of at least one specific group to anchor these feelings to.

Thirdly, through the theme reciprocity, Mahar and colleagues (2013) highlight how a sense of belonging is often fostered by feelings of relatedness or connectedness shared between an individual and an external referent. This relatedness or connectedness may exist due to shared experiences, understandings, or beliefs (Mahar et al., 2013). This theme as a central tenet of belongingness is reinforced within the nursing literature.

Based on qualitative interviews with nursing students during clinical placements, Levett-Jones and Lathlean’s (2008) definition of belonging describes that nursing student’s sense of belonging evolves in response to the degree to which they feel that their personal and professional values coincided with nursing professionals. Likewise, the second
defining feature of belongingness identified by Hagerty et al.’s concept analysis (1992) included a person’s experience of feeling a fit with another group or system based on mutual or complementary characteristics. Mahar and colleagues (2013) recognize that these feelings of relatedness or connectedness that confer belonging may work to produce co-existing feelings of both inclusion and exclusion, especially in cases where one feels as though they belong to a group because they possess characteristics that are socially stigmatized.

Fourthly, through the theme dynamism, Mahar and colleagues (2013) suggest that a complex interplay of societal, personal, and environmental factors both positively and negatively influence an individual’s sense of belonging. These factors that influence belonging may be permanent or may have the capacity to change, suggesting that an individual’s sense of belonging may change over time in response to changes in these factors (Allen et al., 2021; Vivekananda-Schmidt & Sandars, 2018; Strayhorn, 2019). This theme is supported by Strayhorn (2019), drawn from a review of the higher education literature and his work with a variety of student groups including STEM students of color, gay men of color, Latino students, and Black male students. In his book, Strayhorn (2019) drew from intersectionality in examining sense of belonging, suggesting that student’s intersecting social identities, as well as environmental and institutional factors, produce unique ways in which each student personally experiences belonging within academia. Under an intersectional approach, any definition of sense of belonging must recognize the complex interplay of societal, personal, and environmental factors that both positively and negatively influence an individual’s sense of belonging.
Finally, through the theme self-determination, Mahar and colleagues (2013) contend that in order to achieve belonging, one must be both capable and willing to experience it. They recognize an individual’s ability to feel a sense of belonging within a group, as well as that individual’s subsequent choice in deciding whether or not they choose to belong (Mahar et al., 2013). Secondly, Mahar and colleagues (2013) suggest that power differentials produced by systemic influences such as discrimination, or social roles may act as barriers preventing an individual from interacting with a group to achieve belonging or may convince an individual that they are incapable of belonging to a particular group (Allen et al., 2021; Mahar et al., 2013). In order to develop a reciprocal relationship within a group, and ultimately a sense of belonging, one must possess the power and opportunity to do so (Allen et al., 2021; Mahar et al., 2013). Strayhorn (2019) made evident that intersecting social identities, institutional and systemic factors can influence an individual’s experience of belonging. Likewise, Allen and colleagues (2021) argue these same factors can influence an individual’s motivation to belong. Considering that power differentials can create environments that prevent one from achieving belonging within a particular group, it is important to identify whether an individual feels they possess the ability to belong when exploring that individual’s sense of belonging to a particular group (Mahar et al., 2013).

Drawn from each of these five themes, Mahar and colleagues (2013) defined a sense of belonging “as a subjective feeling of value and respect derived from a reciprocal relationship to an external referent that is built on a foundation of shared experiences, beliefs, or personal characteristics. These feelings of external connectedness are grounded to the context or referent group, to whom one chooses, wants, and feels permission to
belong. This dynamic phenomenon may be either hindered or promoted by complex interactions between environmental and personal factors”. Mahar and colleagues (2013) developed this transdisciplinary, multidimensional definition of sense of belonging to promote clarity of the concept. By synthesizing the critical themes among definitions of sense of belonging from across disciplines, Mahar and colleague’s (2013) conceptualization of sense of belonging represents a holistic understanding of the concept, and thus was the definition that guided the research.

2.3 Foundational Theories of a Sense of Belonging

Throughout the literature, several theories have been used as guiding frameworks for definitions of a sense of belonging including Durkheim (1952), Maslow (1968), Schlossberg (1989) and Tinto (1993). Early theorizing within the field of sociology by Durkheim (1951) suggested a link between a sense of belonging and suicide. Durkheim (1951) proposed that suicide varied by the degree of one’s social integration and identified egoistic suicide, which he believed to be caused by an individual’s lack of belonging to the broader society. Within the field of psychology, Abraham Maslow (1968) developed Maslow’s Hierarchy of Needs (MHON) to argue that human behavior is motivated by an intrinsic desire to satisfy five categories of human needs including physiological, safety, esteem, self-actualization, and love and belonging. Satisfying each need is recognized as essential to achieve optimal well-being, while an absence of any need would negatively impact general well-being (Maslow, 1943). Drawn from their qualitative work exploring nursing students’ sense of belonging during clinical placements, Levett-Jones and Lathlean adapted MHON to create the Ascent to Competence framework. Although MHON has received scrutiny that the evidence he
used to support his theory development is largely unscientific, Levett-Jones and Lathlean (2009a) argue that Maslow’s work resonates with people’s lived experiences and can be used to understand and address students’ needs in the clinical environment. The framework was created to identify student’s needs during clinical placements and assist individuals in creating clinical environments that could meet these needs and encourage the development of student’s clinical competence (Levett-Jones & Lathlean, 2009a). Drawing from MHON, the Ascent to Competence framework identified students’ needs as the need for physical and psychological safety and security, the need for belongingness, the need for appreciation and recognition of their contribution to patient care, the need for self-directed learning in an authentic environment, and the need to become confident and capable. (Levett-Jones & Lathlean, 2009a) A recent study in Western Canada utilizing the Ascent to Competence framework to explore belonging among practical nurses found that the framework did not suffice to fully explain participant’s experiences (Manokore et al., 2019). Manokore and colleagues (2019) identified that missing from the framework was participant’s experiences with individuals or systems within the clinical environment that act as gatekeepers and deny individuals the ability to develop belongingness. These findings reflect the theme of self-determination mentioned earlier, which emphasizes that individuals may encounter physical or environmental factors that act as barriers to achieving a sense of belonging within a particular group (Mahar et al., 2013).

Schlossberg’s (1989) theory of mattering and marginality reiterates Maslow’s assertion that belonging, and mattering are fundamental human desires. In addition, Schlossberg (1989) proposes that students who are in unfamiliar or transitional roles or
experiences are at a higher risk of feeling marginalized, providing examples such as freshmen, individuals changing academic majors, and first-generation students. Tinto’s interactionalist theory (1993) argues that student persistence and attrition in higher education is linked to how well a student integrates to the university by engaging in activities such as participating in clubs, academic activities, and developing personal connections. Tinto (1993) argues that students enter university with a wide range of unique background traits that influence how well they will socially and academically integrate into the school. He posits that if a student doesn’t successfully integrate into the social and academic milieu of their educational institution, they are less likely to persist in higher academia (Tinto, 1993). Yet Tinto’s theory has received criticism, in relation to its lack of applicability to minoritized groups, its emphasis on students’ personal responsibility towards academic success without recognizing institutional failures, the use of assimilatory language, and engrained assumptions that students need to break ties with their culture of origin to integrate to academia successfully (Strayhorn, 2019).

Drawing from Maslow (1968), Tinto (1993), Schlossberg (1989), his own intersectional belonging research, and a review of the belonging literature, Strayhorn (2019) wrote a book forwarding his own theory of college students’ sense of belonging. In this book he identified what he believed to be seven core elements of belonging. The first two elements include that belonging is a basic human need as well as a fundamental motive capable of influencing human behavior (Strayhorn, 2019). Thirdly, Strayhorn (2019) argues that belonging exhibits heightened importance in certain contexts, times, and among certain populations such as those who are marginalized in society. The fourth element identifies that a sense of belonging is related to and potentially a consequence of
mattering, that is, that one feels that they are valued, appreciated and matter to others (Strayhorn, 2019). The fifth and sixth elements identify that a sense of belonging is influenced by students’ intersecting identities and that belonging produces positive outcomes (Strayhorn, 2019). Finally, the seventh element suggests that a sense of belonging is capable to change over time and must be continually satisfied (Strayhorn, 2019).

2.4 Sense of Belonging and Student Academic and Mental Health Outcomes in Higher Education

The existing body of literature identifies belonging to be associated with a variety of positive outcomes among students in higher education. Students who report a higher sense of belonging also report greater academic engagement (Clark et al., 2012; De Sisto et al., 2021; Gillen-O’Neal, 2019; Zumbrunn et al., 2014), and report accessing campus services and supports more frequently (Gopalan & Brady, 2019; Yeager, 2016). Belongingness has also been associated with a large degree of positive psychological outcomes in students including improved academic motivation (Pedler et al., 2021; Suhlmann et al., 2018), greater academic self-efficacy (Freeman et al., 2007; Gillen-O’Neal, 2019; Zumbrunn et al., 2014), as well as mental and emotional well-being (Gopalan & Brady, 2019; Sax & Weintraub, 2014; Suhlmann et al., 2018). For example, research by Stebleton and colleagues (2011) found that students who experienced a greater sense of belonging on campus were less likely to report feeling depressed, stressed, or upset throughout the academic year. Furthermore, a greater sense of belonging has been suggested to have a positive effect on student success metrics including grade point average (Glass & Westmont, 2013; Zumbrunn et al., 2014) as well
as academic persistence and retention (Curry & DeBoer, 2020; De Sisto et al., 2021; Gopalan & Brady, 2019; Strayhorn, 2019; Suhlmann et al., 2018). Interventions designed to improve students’ sense of belonging have also been found to be positively associated with student success and well-being. Students who receive an intervention that is designed to normalize feelings of not belonging in the transition to school and reinforce that their sense of belonging will improve with time have been found to achieve a higher GPA (Murphy et al., 2020), report a greater sense of belonging, and report being healthier over a 3-year period than students who did not receive any belonging intervention (Walton & Cohen, 2011). These interventions appear to be particularly important for minoritized students’ success by reducing inequities in student achievement between white and racialized students by half, improving these students’ health and happiness (Walton & Cohen, 2011), and improving retention of these students in higher education (Murphy et al., 2020). Furthermore, the benefits of these belonging interventions appear to extend beyond participants’ academic tenure. For example, those who have received a belongingness intervention reported greater psychological well-being, community involvement, and career satisfaction and success than the control group, even a decade later (Brady et al., 2020). Finally, a greater sense of belonging has been suggested to influence student’s identity formation. For example, minoritized students who experience a greater sense of belonging are suggested to feel a greater connection to their own ethnic heritage (Maramba & Museus, 2013). In contrast, a lower sense of belonging has been suggested to lead to a variety of negative outcomes. A diminished sense of belonging has been associated with increased stress (Aggarwal & Çiftçi, 2021) and suicidal ideation (Van Orden et al., 2008; Vivekananda-Schmidt & Sandars, 2018), has prompted students
to disengage from the learning process, and may increase students’ intention to leave their respective program (Gona et al., 2019; O’Keefe, 2013; Pedler et al., 2021; Strayhorn, 2020b). Specifically, very low levels of belonging among underrepresented racially and ethnically minoritized students has been associated with a much lower level of persistence in higher education (Gopalan & Brady, 2019).

2.5 Sense of Belonging and Students with Racially and Ethnically Minoritized Identities in Higher Education

Strayhorn (2019) suggests that “sense of belonging takes on heightened importance (a) in certain contexts … (b) at certain times … and (c) among certain populations” (p.34) such as those who feel marginalized or unwelcome. Specifically, he argues that belonging may have heightened significance among groups who are marginalized in higher education contexts such as students with racially and ethnically minoritized identities and first-generation students (Strayhorn, 2019). Within higher education, students with racially and ethnically minoritized identities experience unique barriers to belonging. Structural barriers such as racial and ethnic discrimination, exclusionary pedagogies, and underrepresentation within academia and the greater community, may contribute to feelings of exclusion, isolation, and marginalization among students with racially and ethnically minoritized identities that may undermine their sense of belonging within academia. (Caxaj et al., 2018b; Chandauka et al. 2015; Clark et al., 2012; Gardner, 2005; Lane & Ngo, 2020; Loftin et al., 2012; Strayhorn, 2019). In addition, students with racially and ethnically minoritized identities are suggested to be more likely to be first generation students, experience financial constraints (Ackerman-Barger, 2010), and lack adequate social supports which may
further negatively influence their sense of belonging (Strayhorn, 2019). In light of these unique barriers, work by previous scholars consistently suggests that students with racially and ethnically minoritized identities experience a lower sense of belonging in higher education than their peers (Clark et al., 2012; Chaudhuka et al., 2015; Gopalan & Brady, 2019; Johnson, 2012; Johnson et al., 2007; Meeuwisse et al., 2010; Ribera et al., 2017; Strayhorn, 2020b; Strayhorn, 2019).

One of the most negative influences on racially and ethnically minoritized students’ sense of belonging in higher education is discrimination related to their identities. Racial and ethnic discrimination is consistently identified to contribute negatively to students’ sense of belonging in higher education (Dortch & Patel, 2017; Glass & Westmont, 2013; Lewis et al., 2019; Metzger et al., 2020; President’s Anti-Racism Working Group, 2020; Ryerson University, 2020; Strayhorn, 2020a; Strayhorn, 2019). This discrimination is primarily found to be experienced by underrepresented minoritized groups (Clark et al., 2012; Glass & Westmont, 2013; O’Meara et al., 2017) and can cause students to withdraw from relationships with perpetrators, further negatively impacting their sense of belonging (Lewis et al., 2019). Discrimination may be enacted by all members involved in students learning, including faculty, and can extend beyond the classroom into areas of campus, as well as the community (Caxaj et al., 2018b; Dortch & Patel, 2017; Lewis et al., 2019).

Discriminatory acts are likely often unchallenged and undeterred in higher education. Accounts from existing research suggests that discriminatory behaviors in higher academia may often manifest in the form of microaggressions (Clark et al., 2012; Dortch & Patel, 2017; Lewis et al., 2019; O’Meara et al., 2017). Racial microaggressions
generally include verbal and non-verbal everyday forms of racism that are hostile, or derogatory in nature (Mohamed & Beagan, 2018). Microaggressions differ from more overt forms of racism in that they are often subtle and hidden in everyday interactions, making them more difficult to identify and address in the moment (Mohamed & Beagan, 2018; Sue et al., 2007). In addition, students with racially and ethnically minoritized identities may choose to neglect addressing discrimination within the classroom due to fear of power dynamics (Houshmand & Spanierman, 2021) or being labelled as “pulling the race card” (Lewis et al., 2019). Finally, many Canadian university policies designed to address and deter harassment and discrimination in academia have been suggested to be largely ineffective (Henry et al., 2017), and instructors may condone racism by failing to intervene when events occur (Caxaj et al., 2018a).

2.6 Discrimination within Canadian Academia

The incidence and deleterious impact of systemic racism and discrimination within Canadian educational institutions has been criticized by numerous scholars (Bell, 2020; Dryden & Nmorom, 2021; Henry et al., 2017; Henry & Tator, 2009) and professional organizations (Canadian Nurses Association, 2021; Ontario Human Rights Commission, 2020; United Nations, 2017). A recent report from a United Nations Working Group on People of African Descent in Canada wrote that “anti-Black racism and racial stereotypes are so deeply entrenched in institutions, policies and practices, that its institutional and systemic forms are either functionally normalized or rendered invisible, especially to the dominant group” (United Nations, 2017). This report represents a call to action to improve the pervasive racism that exists across all areas of Canada.
Students with racially or ethnically minoritized identities describe diverse experiences of discrimination and othering in Canadian academia that can occur as early as orientation. For example, underrepresented medical students in work by van Buuren and colleagues (2021) described how their social orientations contained implicit messages about who belonged within the medical profession, accentuating feelings of exclusion for those who didn’t fit within the dominant identity. Students with racially and ethnically minoritized identities describe being excluded by their white classmates, frequently receiving questions about their non-white appearance and/or background (Hughes et al., 2021), being questioned in ways that mark them as not belonging and perceive being treated with hostility and suspicion based on their racial identities in both academic (Ryerson University, 2020) and public spaces (Caxaj et al., 2018a; Caxaj et al., 2018b). Ethnocultural related questions represent common microaggressions that position Whiteness as the norm within Canadian society and can heighten students’ sense of not belonging to their profession of study (Hughes et al., 2021). In addition, students with racially and ethnically minoritized identities may also face assumptions of criminality or deviancy (Baker, 2017) and identify feeling tokenized by their university (Caxaj et al., 2018a). Furthermore, these students may frequently be subject to racist jokes their perpetrators perceive to be innocuous (Henry & Tator, 2009; Houshman & Spanierman, 2021), face assumptions of deficiency or intellectual inferiority, experience racial epithets (Baker, 2017; Caxaj et al., 2018a), encounter curriculum materials that denigrate their identities, and receive putdowns related to aspects of their cultural identity such as their clothes, appearance, accent, or foods (Natarajan et al., 2021; President’s Anti-Racism Working Group, 2020). In response to this discrimination, students describe attempting to
conceal their racialized identities to protect themselves from feelings of isolation within the university setting (Caxaj et al., 2018a) and express experiences of not belonging (President’s Anti-Racism Working Group, 2020; Ryerson University, 2020). These feelings of isolation can extend to the larger community which has been characterized as less accepting, and more explicitly discriminatory than the campus environment (Caxaj et al., 2018a).

In addition to the discrimination faced by students, other research has highlighted the hiring practices, systemic barriers, subtle and overt forms of discrimination, and institutionalized Whiteness that marginalize minoritized Canadian faculty, and contribute to their ongoing underrepresentation in both faculty (Henry et al., 2017; Mohamed & Beagan, 2019) and university governance positions (Cukier et al., 2021; Johnson & Howsam, 2020; Universities Canada, 2019). The impact of the underrepresentation of faculty with racially and ethnically minoritized identities on students has also been noted. Recent reports suggest that a ‘culture of Whiteness’ makes it difficult for students with racially or ethnically minoritized identities to thrive personally or academically (Caxaj et al., 2018a), and that these students wish to see more diversity amongst academic and student support staff in order to feel less isolated within academia and more connected to their community (President’s Anti-Racism Working Group, 2020).

2.7 Racism and Discrimination within Canadian Nursing Academia and Clinical Education

Existing reviews of the international literature highlight the extensive breadth of research detailing the pervasive discrimination and marginalization NSREM encounter in both academic and clinical settings (Graham et al., 2016; Koch et al., 2014; Loftin et al.,
2012), with the consequence of this discrimination being a feeling of not belonging (Metzger et al., 2020). Although aspects of experiences with discrimination may be similar across borders, Canada’s unique history of racism, segregation and socialization contributes to unique environments for those pursuing a career in nursing within this context (Henry & Tator, 2009; Katchanovski et al., 2015; Mortel Besa et al., 2021; Poolokasingham et al., 2014). Thus, the ensuing explorations of racism and discrimination within nursing academia and clinical placements will focus on the existing literature within a Canadian context.

Despite often being conceptualized as a career dedicated to social justice, the foundations of Canadian nursing and nursing education have been formed through white hegemony. Canadian nursing schools historically excluded non-white and working-class individuals from obtaining training as registered nurses until the 1950s (Flynn, 2009). Furthermore, subsequent efforts were made to depict nurses within the lens of Victorian ideals of femininity, prioritizing Whiteness, and Eurocentric ideals as central to the profession (Flynn, 2009). Although these policies and practices took place decades ago, the deleterious effects of these actions still linger. For example, Vukic and colleagues (2016) suggest that students’ families and communities still recall these discriminatory practices, and thus, individuals with racially and ethnically minoritized identities may be negatively influenced from considering nursing as a viable career option (Vukic et al., 2016). More recently, Canada’s nursing workforce still remains “disproportionately Caucasian and heteronormative” (Jeffries et al., 2018). Vukic and colleagues (2016) explain that systemic barriers still exist that negatively influence the admission and retention of students with racially and ethnically minoritized identities in Canadian
nursing. This homogeneity within the nursing profession perpetuates dominant approaches to care that exclude the values and ideals of underrepresented groups (Jeffries et al., 2018). As such, success in Canadian nursing programs has been described as being dependent on acquiring cultural knowledge that reflects Canada’s predominant Anglo-European culture (Donnelly et al., 2009).

Within nursing education, experiences of discrimination among NSREM reflect the experiences of minoritized students navigating university life at large. NSREM describe receiving both subtle and overt forms of discrimination from all members involved in their learning including their peers, professors, clinical instructors, nurse mentors, and patients (Donnelly et al., 2009; Hughes et al., 2021; Monteiro, 2018; Paterson et al., 2004; Sedgwick et al., 2014) that reinforce Whiteness as the norm and position the student as a representative of their entire cultural group. These students may be discriminated against (Clarke et al., 2012), be intentionally excluded by their peers, and may face assumptions by others of their inferiority (Donnelly et al., 2009; Monteiro, 2018; Paterson et al., 2004; Sedgwick et al., 2014). Discrimination towards NSREM may target skin tone, ethnicity, accent, and fluency (Paterson et al., 2004; Sedgwick et al., 2014). These nursing students describe receiving frequent questions about their culture and ethnicity that infer non-belonging (Monteiro, 2018); this is also reflected in the extant literature among racialized Canadian physiotherapy students in clinical placements (Hughes et al., 2021). Similar to the broader body of higher education literature, NSREM describe disengaging and remaining silent to avoid encounters that provoke feelings of alienation (Donnelly et al., 2009). Reflecting the culture of Whiteness within healthcare, NSREM and other allied health disciplines describe changing or abandoning some aspect
of their cultural identity such as the way they dress and speak in order to assimilate with white culture (Paterson et al., 2004), succeed in nursing school (Monteiro, 2018) and better connect with their patients (Hughes et al., 2021).

NSREM also face unique forms of discrimination from their clinical instructors. Existing research details that clinical instructors may associate negative qualities about a patient with their racial or ethnic identity, fail to recognize cultural variations in care as acceptable, provide differential treatment to students with racially or ethnically minoritized identities (Paterson et al., 2004), and use discriminatory language (Sedgwick et al., 2014). In some cases, experiences of discrimination can be very explicit. For example, a participant in work by Sedgwick and colleagues (2014) described an incident in which a clinical instructor encouraged a patient to call a student ‘Asian’ when they couldn’t pronounce the student’s name.

NSREM may experience additional forms of discrimination within their curricula. In a recent review focused on racism and white privilege in nursing academia which prioritized including a large number of Canadian studies, nursing curricula were found to often sustain problematic ideologies such as Whiteness and classism that contribute to feelings of difference and othering among these students (Bell, 2020). For example, in a study by Lane and Ngo (2020), a nursing student of Chinese-Vietnamese descent highlighted how a learning activity that asked her to reflect on how she had benefited from white privilege, excluded her from participating in the learning process and failed to consider the perspectives of individuals who were non-Caucasian. Contradictory to the intention of the learning experience, this experience reinforced the participant’s belief that white privilege existed within the nursing program and contributed to their
experience of not belonging. Concerns over pedagogical issues in Canadian nursing academia have prompted scholars to advocate for further exploration of power, privilege, and oppression within nursing curricula (Bell, 2020; Blanchet Garneau et al., 2017; Van Herk et al., 2011).

Finally, NSREM may face unique forms of discrimination from their nursing professors. The aforementioned review by Bell (2020) suggested many nursing educators lack the skills to address racism in the classroom, or teach curriculums that address race, power, and privilege. NSREM describe that nursing educators discriminate through avoidance, impatience, negative tone, negative comments, and a reluctance to interact and communicate with them (Donnelly et al., 2009).

### 2.8 Sense of Belonging and Nursing Clinical Placements

Consistent with what has been found in the broader higher education literature, the existing nursing literature on belonging largely supports that belonging within the clinical environment is important to nursing students and leads to positive academic, and psychological outcomes. Nursing students’ belonging within clinical placements has been frequently explored using the Belongingness Scale – Clinical Placement Experience (BES-CPE) developed by Levet-Jones and colleagues (2009a). Responses to the BES-CPE item “it is important to feel accepted by my colleagues” is consistently among the highest rated by nursing students (Ashktorab et al., 2015; Grobecker, 2016; Kim & Jung, 2012; Leblanc, 2021; Honda et al., 2016). Using the BES-CPE, a higher reported sense of belonging during clinical placements has been found to be positively associated with nursing students’ self-efficacy (Pourteimour et al., 2021), self-respect, self-directed
learning (Kim & Jung, 2012) and workplace satisfaction (Borrott et al., 2016), and inversely associated with perceived stress (Grobecker, 2016).

The positive impact of belonging on nursing students’ clinical learning has been a consistent theme in the nursing belonging literature. Students who perceived belongingness expressed an increased motivation to learn (Albloushi et al., 2019; Honda et al., 2016), and report greater confidence in asking questions to negotiate learning needs (Levett-Jones & Lathlean, 2008). Students explain that belonging provided access to staff relationships that allow for more learning opportunities (Kern et al., 2014) and describe being more self-directed in pursuing these opportunities (Levett-Jones et al., 2007b). In contrast, students who feel alienated describe missing out on learning opportunities and report a diminished capacity to learn (Honda et al., 2016; Sedgwick et al., 2014). Students discussed avoiding asking questions of nursing staff, and instead, chose to avoid nurse mentors as much as possible (Honda et al., 2016). In efforts to improve their chance of belonging, some students describe partaking in actions that had negative implications for patient safety such as conforming to nursing practices they know to be incorrect (Levett-Jones & Lathlean, 2009b), and neglecting to speak up when they believed their patient’s condition was deteriorating (Honda et al., 2016).

Other positive outcomes of a sense of belonging reported by nursing students include feelings of safety, comfort (Levett-Jones & Lathlean, 2008; Sedgwick & Yonge, 2008), and emotional well-being (Levett-Jones et al., 2007b). Student narratives suggested that a lack of belonging led to a wide range of negative emotions such as anger, frustration, confusion, anxiety, disempowerment, low self-worth, despair, dissatisfaction, disengagement, poor confidence, feeling unwanted, and prompted
students to question their career decisions (Kern et al., 2013; Levett-Jones & Lathlean, 2009a; Levett-Jones et al., 2007b; Sedgwick et al., 2014; Sedgwick & Rougeau, 2010).

Among existing works that sought to identify the factors that influence belonging, three studies found no significant difference in overall sense of belonging based on gender (Borrott et al., 2016; Leblanc, 2021; Sedgwick & Kellett, 2015) while one found men to experience a greater sense of belonging (Pourtemoir et al., 2021). One study found no difference in belonging based on age, or year of program (Leblanc, 2021). Additionally, one study found that nursing students in a four-year program reported a greater sense of belonging than those in a two-year program (Sedgwick, 2013). Nursing students’ experiences of belonging also appear to be positively or negatively influenced by the individual characteristics of the student, as well as the actions and behaviors of all members of the healthcare team (Alboushi et al., 2019; Levett-Jones et al., 2009b; Levett-Jones & Lathlean, 2008; Sedgwick et al., 2014; Sedgwick & Yonge, 2008). Levett-Jones and colleagues (2008) suggested that longer clinical placements were likely to improve belonging as students may experience a “settling-in” period early in their clinical rotations characterized by uncertainty and poor rapport with staff. The factors that influence clinical belonging have frequently been explored in relation to singular influences or identity categories that have neglected to interrogate how numerous categories intersect to influence experiences of belonging. In their study exploring the influence of gender on nursing students’ experiences of belonging, Sedgwick and Kellett (2015) recognize this focus on a singular identity characteristic as a limitation of their study. They highlight that other socially constructed categories (such as racialization) intersect and moderate the impact of gender on belonging. They conclude by advocating
for studies similar to the one in this thesis that focus on exploring the social power hierarchies and intersectional identities that influence experiences of belonging.

2.9 Clinical Placement Sense of Belonging and Nursing Students with Racially and Ethnically Minoritized Identities

The influence of racial and ethnic identity on nursing students’ sense of belonging during clinical placements has been seldom explored in the literature. Grobecker (2016) collected race and ethnicity-based data but concluded that no statistical test could be conducted to compare these groups, as some participants identified with more than one racial or ethnic background. Metzger and Taggart (2020) conducted a longitudinal mixed-methods study in which participants were provided with the BES-CPE at 3 separate timepoints. They found that underrepresented minority groups (UMGs) experienced lower clinical belonging than majority students (Caucasian women ages 20-25) at every point in time. UMGs included individuals older than 25, males, non-Caucasians, foreign born individuals, and individuals for whom English was not their first language. Two studies gathered information related to race/ethnicity by asking students to indicate whether they self-identified as a visible minority (Sedgwivck & Kellett, 2015), or to a ‘minority group’ (Sedgwick et al., 2014). Nursing students with racially and ethnically minoritized identities in both samples made up less than 10% of the study participants, with the remainder identifying as Caucasians. Although Sedgwick and Kellet (2015) did not compare these groups, results from the BES-CPE in work by Sedgwick and colleagues, (2015) found that students who identified as First Nations/Aboriginal or Asian were more likely to feel a greater sense of being disliked than Caucasian students, indicated that they felt discriminated against during clinical placements, and identified
that they felt they did not share the same personal and professional values as the registered nurses they worked with. As previously mentioned, a sense of belonging requires an individual experience a feeling of value or respect within a group, as well as a sense of relatedness to that group based on aspects such as shared values (Mahar, 2013). Thus, findings that First Nations/Aboriginal and Asian students felt discriminated against, disliked, and experienced a value incongruence with their nurse mentors has negative implications for their sense of belonging in the clinical environments.

Only three studies were found to explicitly address diversity characteristics and students’ sense of belonging in clinical placements. One student in work by Levett-Jones and Lathlean (2008) identified language and culture as barriers to nursing staff’s acceptance of her. In the qualitative findings of a mixed methods study by Metzger and Taggart (2020), derogatory remarks and racial discrimination that went unaddressed were suggested by nursing students to decrease their sense of belonging. Sedgwick and colleagues (2014) conducted a similar mixed methods study in Western Canada seeking to identify the factors that influence ‘minority students’ sense of belonging. Qualitative interviews suggested that students with racially and ethnically minoritized identities experienced bias and discrimination from all persons involved in their clinical learning which negatively influenced their sense of belonging (Sedgwick et al., 2014). The researcher found no nursing belonging research informed by critical theoretical perspectives, or any work that explicitly recognized the intersectional nature of belonging.
2.10 Literature Review Summary

In summary, a review of the available literature highlights that a sense of belonging is a fundamental human need that engenders positive feelings and outcomes and is influenced by individual’s unique intersectional identities. Among undergraduate students, a sense of belonging has been associated with positive academic and mental health outcomes. An absence of belonging, on the other hand, has been associated with poor academic performance and mental health. For racially and ethnically minoritized students’ numerous structural barriers to belonging exist within academia. These structural barriers extend to Canadian education due to the pervasive systems of discrimination that are deeply entrenched into the social fabric of Canadian society. Within Canadian nursing education specifically, the historicity of white hegemony within the profession informs dominant ways of thinking that privilege Whiteness and problematize difference. As a result, NSREM face unique barriers to belonging, due to the discrimination they encounter within Canadian society and all aspects of their classroom and clinical education. Unfortunately, although racial and ethnic discrimination represent unique barriers to belonging, there is a dearth of literature exploring how nursing students with racially and ethnically minoritized identities experience belonging during their clinical placements.

2.11 Research Problem and Significance

As mentioned in the literature review, the researcher found no nursing belonging research that recognizes the intersectional nature of one’s experience of belonging as well as explicitly recognizes and problematizes the historical and ongoing privilege of Whiteness within the nursing profession. As explained by Strayhorn (2019), belonging
research that fails to recognize students’ intersectional experiences of belonging are likely to fail to grasp the complexity of student’s experiences of belonging. This lack of critical theoretical perspectives within the belonging literature represents a significant gap in our knowledge in exploring how power differentials produced by systemic influences such as discrimination, or social roles may influence an individual’s sense of belonging. Thus, the study in this thesis which was informed by critical and intersectional theoretical perspectives is needed to identify how factors such as power, privilege, and students’ intersecting identities influence experiences of belonging.

In addition, the existing quantitative body of belonging literature has primarily utilized the Belongingness Scale – Clinical Placement Experience (BES-CPE), which is designed to measure an individual’s sense of belonging at one point in time (i.e., during administration). However, belonging is a dynamic experience that can change frequently in response to a complex network of personal and external factors that are similarly often subject to change. Therefore, using quantitative methods that attempt to capture one’s sense of belonging in a fixed manner through pre-designed questionnaires, will likely produce an insufficient understanding of how nursing students’ intersecting identities and other external factors influence their sense of belonging as it evolves over time. Similarly, individuals of a complex background who may identify with more than one racial or ethnic group have often been excluded from quantitative analyses. Quantitative researchers tend to use static, categorical variables to measure race and ethnicity, which fails to capture the multilayered, fluid nature of these identities. In contrast, qualitative methods such as in-depth interviews provide participants with the opportunity to discuss and elaborate on their experience of belonging through open-ended questions. Given the
dearth of literature exploring belonging among NSREM, there is a need for further qualitative research that allows participants to fully describe their unique experiences, to lead to a deeper understanding of belonging as a dynamic, complex phenomenon.

This study, focused on the intersectional nature of belonging as experienced by NSREM in clinical placements, is posed to contribute substantively to nursing knowledge. Firstly, work by Borrott and colleagues (2016) suggests that the degree to which students’ experience belonging during clinical placements may influence students’ future career decisions by impacting their workplace satisfaction. In addition, Jeffries et al. (2018) suggest that promoting a diverse nursing workforce facilitates culturally competent care, patient satisfaction, cultural safety, and access to care for marginalized groups. Thus, in light of a global nursing shortage (World Health Organization, 2020) and a Canadian nursing workforce that has been suggested to lack racial and ethnic diversity (Jeffries et al., 2018; Oudshoorn, 2020), identifying ways to promote belonging among nursing students with racially and ethnically minoritized identities is crucial to support a capable and diverse nursing workforce. Secondly, clinical placements play a fundamental role in supporting the future professional competence of nursing students (Courtney-Pratt et al., 2012). Considering an absence of belonging is detrimental to student clinical learning, a deeper understanding of the factors that impact belonging are required to confront students’ barriers to professional development. Finally, by strengthening our comprehension of how students’ unique intersectional identities and power influence experiences of belonging, the knowledge gained from the study can be used to advise future transformative action designed to promote nursing student belonging and address systemic discrimination through research, education, and policy.
2.12 References


https://doi.org/10.1080/13613324.2018.1511528


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3 Chapter 3: Methodology and Theoretical Underpinnings

3.1 Philosophical Underpinnings

3.1.1 Paradigm

A research paradigm is often referred to as a worldview and refers to a set of beliefs that define the nature of the world and provide a specific lens through which to explore phenomena (Polit & Beck, 2021). Describing the underlying philosophical underpinnings of the research is important, as they clarify assumptions regarding the ontology, epistemology, methodology and methods for a research study (Singh, 2019). The work in this thesis aligns with the transformative paradigm. Axiologically, researchers working within the transformative paradigm pursue work with an explicit purpose of advancing social justice, human rights, and respecting cultural norms (Mertens, 2010). As explained by Mertens (1999), a researcher “who works within this paradigm consciously analyzes asymmetric power relationships, seeks ways to link the results of social inquiry to action, and links the results of the inquiry to wider questions of social inequity and social justice”. The purpose of the study was to explore the clinical placement experiences of belonging among nursing students who self-identify as having a racially or ethnically minoritized identity. Using an intersectional lens, the researcher explored how these experiences of belonging were influenced by participants intersecting social categories and other systems of power in order to deepen our understand of how these factors influence belonging. As the purpose of conducting the research was to explore issues of power and inform anti-racist and anti-oppressive transformative action within nursing education, the purpose of the research aligns with the mandate of work within the transformative paradigm.
3.1.2 Ontology

Ontology is concerned with assumptions regarding the nature of reality, and what aspects of reality are apprehensible (Singh, 2019). Instead of aligning with one particular understanding of reality, researchers working within the transformative paradigm acknowledge that multiple perspectives exist regarding what is assumed to be real but do not take a definitive stance regarding whether or not there is one reality waiting to be discovered (Cram & Mertens, 2016). Instead, the researcher’s role is to explore the source of these multifaceted claims of reality. Transformative researchers need to identify the values and systems that privileges one individual’s perception of reality over another and work to illuminate the consequences of accepting privileged realities (Mertens, 2021). Researchers working within this paradigm explicitly recognize power issues, by maintaining that perceptions of reality need to be interrogated within the larger realm of political, cultural, and economic values that give privilege to some realities over others and perpetuate oppressive structures and policies (Mertens, 2021). Within this ontological framework, the researcher seeks to promote social justice initiatives by offering versions of reality that create an awareness of the clinical experiences of belonging among NSREM.

3.1.3 Epistemology

Epistemology encompasses our assumptions about how knowledge is created, acquired, and transferred, as well as assumptions regarding the relationship between participant and researcher (Singh, 2019). Within the transformative paradigm, power and privilege are seen to construct knowledge, recognizing that knowledge is socially and historically situated (Cram & Mertens, 2016). Knowledge is considered transactional,
meaning it is co-created between the researcher and participant, and thus, requires the researcher consider power differentials in the relationship between the researcher and participant (Mertens, 2010). When working with marginalized and vulnerable groups, the researcher needs to develop collaborative strategies that value the experiences of participants and ensure accurate understandings of these experiences (Mertens, 2021). In alignment with this epistemological framework, the researcher will identify the strategies utilized to facilitate trust and collaboration with participants, as well as reduce power imbalances between the researcher and participant.

3.2 Theoretical Orientation

3.2.1 Intersectionality

The researcher utilized an intersectional lens to examine how student’s multiple intersecting identities influenced their sense of belonging in the clinical environment. Researchers using an intersectional lens deny that social conditions are produced by any single factor. Rather, intersectionality theory posits that social inequities are the result of the complex interactions between multiple intersecting social categories and systems of power that produce interdependent forms of privilege and oppression in society (Hankivsky, 2014). Using this lens enables an analysis of privilege and oppression as they can be experienced simultaneously and are subject to change in response to changes in the situations and contexts of individual’s lives (Hankivsky, 2014). By exploring multiple intersecting social locations and systems of power simultaneously, researchers who utilize an intersectional framework produce a more comprehensive understanding of the interrelated factors that perpetuate inequities (Chinn & Kramer, 2018). Researchers using an intersectional lens strive to link the experiences of individuals to larger societal
structures and influences as a means of illuminating how power relations shape these experiences (Hankivsky, 2014). As explained by Strayhorn (2019), belonging research that fails to recognize students’ intersectional experiences of belonging are likely to lead to ineffective solutions that fail to grasp the complexity of student’s experiences of belonging. By recognizing the intersectional nature of belonging, intersectionality theory provided a useful lens in understanding the nuance and complexity of how NSREM experience belonging during their clinical placements. Furthermore, qualitative research informed by an intersectional lens is integral in illuminating differences and similarities within and between groups by providing participants with the opportunity to speak about their experiences of power, discrimination, and resilience (Hunting, 2014). Nursing studies employing intersectionality have examined the impact of race and ethnicity in relation to discrimination and stigma, utilizing the individual experiences of participants to identify the drivers of inequality, and use this information to promote social justice through advocacy and activism (Ruiz, 2020). For these reasons, an intersectional lens was chosen as a useful framework to understand how structures of inequity within society shape nursing students’ experiences of belonging.

The philosophical assumptions of intersectionality informed research are particularly amenable with the qualitative methodology of the study in this thesis. Researchers employing these approaches share the assumption that the context of participant’s lives, and experiences affects their behaviors, and researchers need to identify and consider these contexts to identify how they might influence individual’s actions and perceptions (Hunting, 2014). Similarly, researchers utilizing an intersectional framework and qualitative methodology must acknowledge the importance of minimizing
power imbalances between researcher and participants, as well as recognize the importance of including the participation of individuals from multiple diverse perspectives (Hunting, 2014).

3.3 Methodology

To meet the aims of the research, the researcher utilized an interpretive descriptive qualitative study design. Nursing scholar Dr. Sally Thorne developed interpretive description in recognition that nursing research located within the traditional approaches to qualitative inquiry were often constrained by scientific foundations that were not always relevant to the complex and diverse nature of nursing inquiry, and often not in keeping with the discipline’s requirement for useable knowledge (Thorne, 2016). Instead, interpretive description is grounded in the ‘so what’ of research, prioritizing that the knowledge generated would lead to action or insight that has utility in the real world (Thorne, 2016). As a means of developing actionable knowledge, interpretive description is consistent with the value orientation of the transformative paradigm. A focus on creating actionable knowledge also aligns with the purpose of the study in facilitating transformative action to address systemic barriers to belonging for NSREM. Furthermore, interpretive description research is also commensurate with the transformative paradigm because it seeks to explore the subjective and experiential elements of a phenomenon, recognizing that many of the realities we seek to understand are socially constructed and shaped by social, structural, cultural, and historical contexts (Thorne, 2016).

Interpretive description is not a prescriptive methodology, but rather encourages borrowing from various data collection and analytic strategies, as long as they maintain
logical integrity and consistency within the positioning of the research (Thorne, 2016). The purpose of the methodology is to create an understanding of a common issue that recognizes the complexity of that issue, acknowledges the value of each individual expressed perception, but also recognizes that perceptions can be contradictory to one another and may not represent any ‘truth’ (Thorne, 2016). By facilitating this understanding of an issue, researchers utilizing interpretive description seek to illuminate and contextualize observable patterns of human experience and deconstruct assumed knowledge in the hope that the knowledge generated can be applied to the betterment of people’s lives (Thorne, 2016). The purpose of this research was to explore the clinical placements experiences of belonging among NSREM. As the purpose of interpretive description is to answer research questions about participant experiences from a holistic perspective (Burdine et al., 2020), it was determined to be well suited to achieve the study’s purpose of gaining a holistic understanding of participant’s experiences of belonging. Interpretive description was deemed to be a suitable methodology for the study because it aligns with the philosophical underpinnings of the research, is well suited to the interdisciplinary underpinnings of nursing science, allows for the exploration of the social, historical, structural, and cultural influences of human experience, and allowed the researcher to borrow from a wide variety of methods to ensure that the research design was best suited to meet the purpose of the study.

3.4 Methods

3.4.1 Data Collection

There is no pre-determined structure to follow for data collection within an interpretive descriptive study (Thorne, 2016). Rather, researchers need to devise a
reasonable logic that identifies how their approach is well suited to answer the research questions (Thorne, 2016). The purpose of the study was to explore participant’s experiences of belonging. Interviews were utilized as the primary data-collection method as they allowed the researcher the opportunity to explore the experiences of participants in an in-depth manner (McGrath et al., 2018), thus reflecting the aims of the research. Interview questions were open-ended to generate in-depth discussion. There were no time-constraints on participant’s answers to ensure they have adequate time to answer questions fully and the interviews were semi-structured. Consistent with semi-structured interviews the researcher developed an interview guide to structure what is discussed during the interview. A semi-structured approach to interviewing was deemed appropriate because it allows the researcher to use pre-determined topics to structure the discussion in a way that is relevant to answering the research questions. Moreover, the flexibility of semi-structured interviews was chosen to provide the researcher some latitude to diverge from the interview guide based on participant responses as well as probe these responses in order to elicit more specific and in-depth information. Finally, semi-structured interviews were chosen because they can be used to elicit narratives from participants that can contribute to an understanding of the complexities of their intersecting identities within their unique context (Narvaez et al., 2009). Thus, the researcher used semi-structured interviews as a means of examining how participant’s experiences of belonging were influenced by their unique social locations.

Questions in the interview guide were designed to specifically address the research questions. For example, the first research question seeks to explore how NSREM experience belonging during their clinical placements. Thus, to facilitate
answering the first research question, the researcher posed the question “Could you tell me about your experience of belonging within the clinical environment?”. In order to identify and critique how inequality operates, researchers employing an intersectional lens need to identify the power structures that create conditions that shape individual’s intersectional experiences (Cho et al., 2013). To elicit discussions about power and privilege, intersectionality informed prompts designed by Etherington and colleagues (2021) were adopted to structure the interview guide for this study.

Due to the dangers presented by the ongoing COVID-19 pandemic, interviews took place using the video conferencing software Zoom. As participants experiences of belonging had the chance to involve sharing information of an intimate or sensitive nature, Zoom was considered a more appropriate choice than telephone interviews, as telephone interviews are inadvisable if sensitive subject matter is being shared (Polit & Beck, 2021). Furthermore, given the limited fiscal resources of the research, Zoom provided a cost-effective means of providing face-to-face interviews regardless of geographical distance from participants and allowed for both a visual and auditory record of the interview (Polit & Beck, 2021).

3.4.2 Opportunities to Build Trust and Reduce Power Imbalances with Participants

Researchers working within the transformative paradigm need to thoughtfully consider how they can collaborate with participants to create an ongoing trusting and respectful relationship. Creating environments that are trusting, support diversity, and accommodate differing points of view are integral to facilitating open and honest interviews (Cargo & Mercer, 2008). The characteristics of a trustworthy researcher are individuals who are accessible, approachable, attentive, and honest (Wilkins, 2018). To
espouse these characteristics, the researcher frequently encouraged participants to approach him with any questions or concerns, responded to participants expediently, and was truthful, open, and welcoming in these responses. In addition, trustworthy researchers are individuals who are humble, and respectful (Wilkins, 2018). Thus, the researcher sought to create an environment which positioned participants as individuals with expert knowledge on their personal experiences and made efforts throughout each interview to recognize the value of their contributions and experiences to the co-production of knowledge.

The researcher can use an information sheet as an accountability measure to reflect on whether he has acted in ways that are trusting and respectful. The details provided in an information sheet act as a means of obtaining informed consent, but also provide a written account of what conditions the researcher has promised to uphold throughout the research encounter (Guillemin et al., 2016). After completion of each interview, the researcher debriefed with each participant to see if they believed that the researcher had fulfilled what they promised to do in the information sheet (Guillemin et al., 2016). The researcher continually reflected upon this feedback in his reflexive journal to inform his conduct in future interactions with participants.

Providing opportunities for the researcher and participant to develop rapport prior to the interview is an effective means of developing trust with participants (Elmir et al., 2011; Karnieli-Miller et al., 2009). To provide an opportunity to establish rapport, the researcher began each interview with a conversational, open-ended questions such as, “Could you tell me about yourself?” or “How is school going?”. Engaging in small talk and appropriate researcher self-disclosure supported building trusting relationship by
minimize power imbalances, creating a less intimidating environment, and enhancing the reciprocal nature of interviewing (Elmir et al., 2011).

Researchers working within the transformative paradigm also need to minimize any potential power imbalances between the researcher and participants that might disenfranchise or harm the participants under study. Strategies to reduce power imbalances involved providing participants with the opportunity for participants to contribute towards the research design. Providing opportunities for participants to contribute towards the research design can reduce the risk of reinforcing inequities or social injustice (Abrams et al., 2020). Thus, the researcher sought to provide opportunities for authentic collaboration during data collection, and dissemination. During data collection, the researcher encouraged participants to critique the research methods, as well as provide recommendations about actions they believe are required by relevant decision-makers based on the findings of the study (Karnieli-Miller et al., 2009). The researcher used this feedback to explore opportunities for change (i.e., altering the interview guide) and ensure recommendations based on the findings of the study are participant driven. Finally, to aid in knowledge translation, the researcher plans to collaborate with educators and students in his role as the graduate representative of Western Nursing’s Decolonization/Anti-Racism/Anti-Oppression/ Committee to determine the most effective means of disseminating the research findings.

3.4.3 Sample Size

Samples in Interpretive Descriptive studies typically include five to thirty participants, but can be used with almost any sample size, depending on the nature of the research question. (Thorne, 2016). In deciding upon an appropriate number of
participants, Thorne (2016) suggests considering “how many instances of a thing would we need to include in our observations and analysis in order for the findings to have any merit to those from whom we are conducting the research?”. The intent of the research is to conduct an in-depth exploration of the experience of belonging among nursing students with racially and ethnically minoritized identities. According to Thorne (2016), if a review of the existing body of literature suggests that what is needed is an in-depth exploration of the subjective experiential nature of a phenomenon, then a smaller number of participants is likely to produce useful information. As evidenced from the earlier literature review, there is a paucity of information within the existing body of literature exploring the clinical placement experiences of belonging among NSREM. The researcher sought to obtain between seven and twenty participants. A minimum of seven participants was deemed appropriate because it is a range consistent with other interpretive descriptive studies and was considered a reasonable number of participants to produce useful information based on the paucity of available literature on the topic. A maximum of twenty participants was chosen to ensure sufficient depth of exploration of each individual’s experience. Finally, Thorne (2016) recognizes time and resources as reasonable elements that dictate the limits of a sample size. Accordingly, a maximum of twenty participants was deemed a feasible amount in consideration of the time and resource constraints of a thesis project. Overall, the researcher conducted interviews with eight participants across two Ontario Schools of Nursing. In interpretive descriptive studies, Thorne (2020) argues against making data saturation claims by recognizing that participant experiences in the applied disciplines theoretically contain infinite variations. Instead, Thorne (2020) encourages focusing on whether the data collected has added
enough meaningful insights to an area of research to the point that it warrants reporting. Hence, the researcher decided that sufficient data collection had been reached when enough rich data was collected that he deemed to provide new insights that substantially contributed to current understandings of belonging, and when no new insights were developed from subsequent interviews.

3.4.4 Data Analysis

Data analysis was informed by intersectional theoretical perspectives and followed an inductive analytic approach of the six phases of thematic analysis highlighted by Nowell and colleagues (2017). A thematic analysis was chosen because it is a highly flexible approach that is commensurate with interpretive descriptive studies and is a form of analysis that is easily understood by novice researchers (Nowell et al., 2017). Furthermore, thematic analysis can be used to examine the experiences and personal meanings of participants (Nowell et al., 2017), which aligns with the study’s purpose of exploring the clinical placement experiences of belonging among NSREM. Data analysis and data collection occurred concurrently and informed one another in an iterative process (Thorne, 2016).

In keeping with the tenets of interpretive description, intersectionality, and thematic analysis, data analysis began with reflexivity. Reflexivity was initiated through a process of critical self-reflection. Furthermore, the researcher continually engaged in reflexivity throughout the research process by documenting personal reflections shortly after each participant interview and throughout each stage of the research process. Reflections allowed the researcher to continually consider how ongoing research processes may be shaped by his preconceptions, values, and interests (Hankivsky, 2014;
Hunting, 2014). To guide these reflections, the researcher utilized Patton’s (2015) framework for reflexive inquiry. Patton (2015) provides three categories of reflexive questions for the researcher to reflect upon throughout the research process. These categories include questions about the researcher (e.g., how have my perceptions/background affected data analysis and collection?), the participants (e.g., how do I perceive participants?) and about the study audience (e.g., how does the audience make sense of what I give them?). Finally, researchers working within the transformative paradigm are committed to producing actionable knowledge that can be used towards the improving people’s lives. To support these aims, additional questions that guided the researcher during data analysis included those detailed in Hankivsky and colleagues (2014) intersectionality-based policy analysis framework (IBPA). The IBPA framework includes a list of 12 descriptive and transformative questions designed to guide an intersectional analysis. Descriptive questions within the framework are relevant to generating critical background information and revealing hidden assumptions. Transformative questions are intended to guide the researcher in creating recommendations and solutions that are relevant to promoting structural change and reducing inequities.

Phase one of thematic analysis involves the researcher familiarizing themselves with the data and was accomplished through repeated readings of the data (Nowell et al., 2017). To assist in data analysis, the researcher created handwritten notes during each interview to highlight concepts that he deemed significant at the time. After each interview was completed, the researcher transcribed each interview to begin becoming immersed in the data. Upon completing transcription, the researcher reviewed the
transcriptions again to ensure accuracy as well as reviewed his handwritten notes to remind himself of the context within which understandings of the phenomenon took place. Phase two of thematic analysis involves generating initial codes to arrange the unstructured data and to begin to develop an understanding of similarities and differences within the data. Consistent with an inductive analytic approach, the researcher identified thematic patterns and recurring ideas that appeared regularly within the data and recorded them in a separate code book. Intersectionality informed research often employs multistage analyses to develop an intersectional understanding of participant experiences (Hunting, 2014). Using intersectional methods of coding recommended by Bowleg (2008), the researcher employed three separate coding strategies including open, axial, and selective coding.

In the open coding phase, the researcher conducted a line-by-line analysis of each transcript to break data down into discrete codes and interpret meanings within the raw data (Thorne, 2016). Within this stage of coding, Bowleg (2008) suggests looking for codes that represent an additive approach to intersectionality to isolate the meaning of each social identity prior to understanding how these identities intersect. For example, this stage may use separate codes for racism or sexism that do not yet explore the potential intersections of these two experiences. Using recommendations by Thorne (2016), early analysis included grouping codes representing similar ideas into non-descriptive groups such as “Category A Data”. These non-descriptive categories allowed the researcher to slow down the analytic process and avoid fitting the data to themes too quickly, which Thorne (2016) advises against.
In phase three of thematic analysis, codes from phase two are collated to identify recurrent experiences across the data referred to as themes (Nowell et al., 2017). To begin developing themes, the researcher engaged in a round of axial coding. Axial coding involves grouping the open codes into more distinct categories in an attempt to make stronger connections across the data and more fully explain the phenomenon of interest (Thorne, 2016). Using an intersectional lens, codes may also be refined within this stage to identify intersections of oppression, such as a code to identify the intersections of race and sexism (Bowleg, 2008).

In phase four of data analysis, themes devised in phase three are now further refined and also reviewed to ensure that the themes reflect the meanings within the entire data set. To achieve this, the researcher conducted a round of selective coding, which involves combining existing themes to identify core themes of the data. Bowleg (2008) highlights that in the selective coding phase, themes are further refined to reflect intersectional experiences. Bowleg (2008) provides an example of what a code exploring intersectional experiences may look like at this stage such as “Black lesbians’ experiences of violence reflect intersections of racism, sexism and heterosexism”.

Stage five of data analysis involves identifying what is of interest about each theme within the data and asks the researcher to consider how each theme reflects the research questions (Nowell et al., 2017). In addition to identifying how social identities influence individual’s experiences, researchers employing an intersectional lens must identify, analyze and critique the institutional and societal powers that perpetuate marginalization (Núñez, 2014). To meet these goals, the researcher employed Núñez’s (2014) multilevel model of intersectionality, designed to enhance the analytic potential of
intersectionality. Within this model, the first level of analysis involves examining how social categories such as race and gender relate to one another to create social positions and hierarchies (Núñez, 2014). In the second level of analysis, the researcher is encouraged to examine “domains of power” (Núñez, 2014) including organizational, representational, intersubjective, and experiential. The organizational domain encompasses examining the social structures that influence experiences, the representational domain includes discursive practices that shape experiences, the intersubjective domain involves how interpersonal interactions influence experiences, and the experiential domain examines how participants construct narratives about their own experiences. The last level of analysis titled historicity examines the broader interlocking systems of power as they evolve over time such as social power and classification, thus highlighting systemic issues that shape experiences. Núñez’s (2014) model was chosen as it is in keeping with the tenets of the transformative paradigm of analyzing power relations and linking the results of the inquiry to wider questions of social inequity and social justice. Finally, stage six of thematic analysis involves producing the report, at which point the researcher produced a scholarly account of the data based on the earlier analyses.

3.4.5 Setting and Sample

Although based in London, Ontario, the researcher gathered students from undergraduate nursing institutions in medium-sized cities across Ontario. A medium sized city is defined by the Government of Canada (2021) as a city with a population ranging from 100,000 to 1 million people. By explicitly examining nursing students’ experiences of clinical placement belonging within middle-sized cities, the goal was to
produce understandings of belonging tailored to these specific contexts. As suggested by Sedgwick and colleagues (2014) in their Canadian-based nursing student belonging research, research within multiple academic institutions is required to foster a deeper understanding of nursing students’ sense of belonging. For that reason, gathering participants from more than one academic institution was deemed beneficial to explore how NSREM experience clinical placement belonging across differing educational contexts. Researchers working within the transformative paradigm are committed to producing knowledge that can be used to inform transformative action. Thus, after receiving ethical approval from Western University’s Research Ethics Board, the researcher sought to obtain participants from a maximum of four academic institutions located in Ontario mid-size cities that have an established nursing committees dedicated to anti-racist/anti-oppressive transformative change. By gathering participants from schools that have committees that are currently engaging in transformative action, the knowledge produced within these academic contexts can be used to inform ongoing work within these committees. Drawing from a maximum of four academic institutions was deemed a feasible amount in consideration of the time and resource constraints of a thesis project. During the study, the researcher ultimately drew participants from two Schools of Nursing, as many of the Schools of Nursing he contacted did not have established committees dedicated to anti-racism.

To reflect the aims of the study, Ontario nursing students in undergraduate nursing programs who self-identify as having a racially or ethnically minoritized identity constituted the sample. To select eligible participants, inclusion criteria included individuals: (a) who self-identify as having a racially or ethnically minoritized identity;
(b) are able to read and speak English in order to be able to converse with the researcher; 
(c) are currently enrolled in an Ontario baccalaureate nursing program; and (d) who have fully completed at least one clinical rotation through their program. Nursing students who have not had a clinical experience, or who have dropped out or failed from the program were excluded from participation.

3.4.6 Sampling Strategy

The researcher utilized both purposive and snowball sampling strategies. Purposive sampling is frequently used in qualitative research and involves identifying and choosing participants that have a rich experience of the phenomenon of interest (Palinkas et al., 2015). By choosing those with a rich experiential background, purposive sampling provides a mechanism to recruit individuals that can provide a unique insight and a deeper understanding of the phenomenon of interest (Thorne, 2016). Considering the purpose of the study is to gain a deeper understanding of the experiences of belonging, a purposive sampling strategy was deemed appropriate. To prioritize recruiting a diverse sample, the researcher employed maximum variation purposive sampling. Maximum variation sampling is a strategy for purposive sampling that involves purposefully choosing participants based on variation of a particular dimension of interest (Polit & Beck, 2021). The purpose of this approach is to ensure that people with diverse background are represented in the sample, and to enrich and challenge emerging conceptualizations (Polit & Beck, 2021). Using maximum variation, the researcher prioritized recruiting participants from different self-identified social locations to ensure that any knowledge claims will be made from a diverse sample. Ensuring a diverse sample also aligns with the intersectional theoretical perspectives guiding the study by
allowing the researcher to analyze how multiple and unique intersecting social locations interact with structures of oppression to influence sense of belonging.

Individuals with racially and ethnically minoritized identities may be difficult to recruit due to concerns such as mistrust of the research process, the perceived personal risks associated with identifying as a member of a particular group (i.e., fear of loss of privacy), uncertainty regarding who will benefit from the research, or the sensitive nature of the research question (i.e., sharing experiences of clinical placement belonging) (Ellard-Grey et al., 2015). Due to the potential difficulty of gathering participants, the researcher supplemented purposive sampling strategies by seeking opportunities for snowball sampling. Snowball sampling involved asking existing participants to refer individuals who may have interest in participating given their experience with the phenomenon of interest. (Polit & Beck, 2021). Given the limited resources afforded by the researcher, snowball sampling was conducted as it is cost-effective, and is an effective means of recruiting participants from vulnerable or hidden populations (Polit & Beck, 2021).

School work, the time commitments of research participation, and uncertainty about the topic of interest represent potential barriers for student participation in research (Far, 2018). In order to assist in student recruitment, the researcher engaged in both active and passive recruitment strategies. Passive recruitment strategies involved promoting awareness of the research project within the target population and relying upon participants to approach the researcher (Far, 2018). To increase awareness of the research project across relevant nursing faculties, the researcher developed a recruitment letter detailing the purpose and aims of the research and distributed the letter through
mass emails. Through this approach, students were encouraged to initiate communication with the researcher through e-mail. In addition to passive forms of recruitment the researcher engaged in active recruitment strategies. Active forms of recruitment are regarded as more effective means of promoting student recruitment than passive methods of recruitment and involve identifying and pursuing recruitment from within a specific group (Far, 2018). Active recruitment strategies involved the researcher engaging directly with relevant student nursing groups (i.e., student nursing associations) to disseminate the recruitment letter to promote awareness of the study within the target population.

3.4.7 Ethical Considerations

Prior to the study, the researcher obtained ethical approval from Western University’s Research Ethics Board. To ensure informed consent was achieved, participants were provided with written materials through a Letter of Information and Consent. The Letter of Information and Consent detailed the purpose of the research, use of data, how participants identities and data will be protected, any potential benefits and risks, and any other relevant information needed to achieve informed consent. All of the recruitment methods encouraged prospective participants to contact the researcher via email. After receiving an email from prospective participants, the Letter of Information and Consent was sent to interested individuals via email. The researcher encouraged prospective participants to review the content and approach the researcher with any questions. The Letter of Information and Consent was provided to participants multiple days in advance of any interview to ensure they have adequate time to consider their participation. Prior to a consent form being signed, the researcher reviewed the Letter of Information and Consent with participants and provided further opportunity for
participants to ask any clarifying questions about the research. Participants were informed that their involvement was voluntary and that they could withdraw their consent to participate at any time. Additionally, the researcher asked for consent to continue on an ongoing basis throughout the interviews.

To ensure data security, interview transcripts and video recordings are stored in a password-protected Western OneDrive™ server that only the research team has access to. Participants were asked to provide pseudonyms of their names that can be used to replace any identifying information. As anonymity is the best means of maintaining participant confidentiality (Polit & Beck, 2021), identifying information within audio transcripts such as names, addresses, or cities were replaced with pseudonyms. Although the anticipated risks towards study participants were expected to be minimal, the researcher recognized that exploring experiences of belonging may involve participants sharing intimate details of their experiences that had the chance to elicit an emotional response. To minimize any potential harm, students were directed to free mental health support during a debrief session immediately after completion of the interview. As the researcher gathered participants that identified as having racially and ethnically minoritized identities, the researcher offered services that are tailored to support the unique needs of individuals from these specific populations.

3.5 Approaches for Creating Authenticity and Rigor

For interpretive descriptive studies, Thorne (2016) highlights numerous principles that can enhance the credibility of qualitative inquiry. The following section will highlight how the researcher has attempted to follow the principles relevant to the research design including epistemological integrity, representative credibility, analytic logic, interpretive
authority, disciplinary relevance, and pragmatic obligation, moral defensibility, contextual awareness and probable truth, (Thorne, 2016). Additionally, this section will detail strategies for knowledge translation.

3.5.1 Epistemological Integrity

*Epistemological integrity* refers to an alignment between the underlying assumptions regarding the nature of knowledge, the research question, and the research process (Thorne, 2016). Within this section, the researcher has explicated the philosophical underpinnings from the study, highlighting conceptual alignment between paradigm, ontology, epistemology, methodology, and methods. To continue to promote epistemological integrity, the researcher will thoughtfully reflect throughout every step of the research process during dissemination to ensure that any future decisions continue to align with the epistemological positions of the research.

3.5.2 Representative Credibility

Achieving *representative credibility* requires that knowledge claims made through the research are appropriate based on how the phenomenon was sampled (Thorne, 2016). As the researcher sought to explore experiences of belonging among students with racially and ethnically minoritized identities, maximum variation purposive sampling was adopted to enhance *representative credibility*. Using this sampling strategy allowed the researcher to successfully recruit participants from varying social locations, reflecting the purpose and scope of the research and ensured that knowledge claims were made from a diverse sample.
3.5.3 Analytic Logic

Analytic logic refers to evidence that the reasoning behind research design is made explicit by the researcher (Thorne, 2016). Throughout this, the researcher has shown transparency by providing justification for each subsequent research design choice the researcher. During the publication of results, the researcher will consult with educators and students to determine the best means of knowledge dissemination to support the transformative intentions of the research.

3.5.4 Interpretive Authority

Interpretive authority refers to the degree to which the researchers’ interpretations are trustworthy, and not rooted in their own experience or bias (Thorne, 2016). It requires that the researcher implement structures within the research process to allow them to check their own interpretations against those of their research subjects. The researcher enhanced interpretive authority by continually practicing reflexivity throughout the entire research process, maintaining an audit trail that provides readers with enough context to examine and critique research design decisions. He also ensured that quotes or thick descriptions of participant data were provided from the data to support transparency in the findings (Thorne, 2016). The interview guide assisted the researcher in facilitating discussions about the research topic with participants that yielded rich data. For example, the use of open-ended questions and probes detailed in the interview guide was an effective means of producing generative responses (Bearman, 2019). Furthermore, the researcher also provided participants with opportunities to drive discussion topics related to their experience of belonging and critique the research design which represents an effective means of eliciting rich data (Bearman, 2019).
3.5.5  Disciplinary Relevance & Pragmatic Obligation

*Disciplinary relevance* and *pragmatic obligation* refer to whether the study has practical application towards the nursing discipline as an applied profession and requires the researcher to be cognisant of how research findings might impact individuals (Thorne, 2016). The primary purpose of the study was to explore the experiences of clinical placement belonging among nursing students with racially and ethnically minoritized identities. The findings highlighted the importance of improving students’ experiences of belonging during their clinical placements and revealed the discriminatory structures that negatively impacted participants’ experiences of belonging. As every member involved in nursing students’ learning can influence their sense of belonging (Albloushi et al., 2019; Sedgwick et al., 2014), the findings of this study can be accessed by a variety of nursing professionals and relevant decision makers to inform future practice. Now that the study is completed the researcher is working towards facilitating knowledge translation through publication. In alignment with the tenets of work within the transformative paradigm, the researcher decided to sample from universities who already have committees dedicated to anti-racist/anti-oppressive transformative action. By sampling from universities with anti-racist/anti-oppressive committees, the researcher plans to utilize his position as the graduate representative of Western University’s School of Nursing Decolonization/Anti-Oppression/Anti-Racism Committee to disseminate the findings of this study within these groups.

3.5.6  Moral Defensibility

*Moral defensibility* refers to whether the researcher provides a reasonable argument that exploring the research question is necessary and articulates how the
knowledge generated by the research will be utilized (Thorne, 2016). Within this thesis, the rationale and purpose of generating knowledge through this research can be found through the purpose statement section that was based on a thorough review of the literature. In addition, the researcher has also highlighted multiple means by which he intends to disseminate the knowledge produced by the research in a way that is relevant to informing action-oriented transformative initiatives.

3.5.7 Contextual Awareness & Probable Truth

*Contextual awareness* and *probable truth* require the researcher to recognize that the knowledge produced is valid until newer knowledge is created that provides a compelling reason to abandon it, and is contextually bound (Thorne, 2016). Thus, the findings from this thesis should be considered in future research on belonging until further knowledge on this topic is developed. However, it is also important to note that the research findings of the proposed study may not be applicable across settings or over time.

3.6 Knowledge Translation

Knowledge translation refers to the process of disseminating, exchanging, and applying knowledge and should support the goals of the research. The knowledge translation strategies for the study are referred to by The Canadian Institutes of Health Research (2015) as *diffusion and application*. *Diffusion* refers to knowledge translation strategies that are most likely to be accessed by audiences that already actively seek out research evidence. As the researcher hopes to disseminate the knowledge produced from the study to inform future transformative action in academia, the target group for knowledge translation strategies should include researchers, educators, and other relevant academic
decision makers. Considering researchers, educators, and academic decision makers typically seek out research evidence to support their work, Diffusion strategies such as academic publication and conference presentations represent effective strategies for knowledge translation. Thus, to facilitate knowledge translation, the research will be published in Western University’s open access thesis repository, research journals, and presented at academic conferences.

*Application* refers to the process of actively engaging with knowledge users to put knowledge into practice. As a nursing educator, the graduate student representative of Western Nursing’s Decolonization/Anti-Racism/Anti-Oppression Committee and as a member of the Western/Fanshawe Baccalaureate Nursing Curriculum Review Committee, the researcher will continue to collaborate with faculty, students, and other relevant decision makers to apply the knowledge to relevant nursing contexts. He will also seek to collaborate with Western University’s EDI office and the Canadian Association of Schools of Nursing for the purpose of knowledge translation. Additionally, the researcher developed relationships with other equity, diversity, and inclusion nursing education groups when choosing which schools to sample. Thus, the researcher will re-engage with these groups after the completion of the study to seek out opportunities for collaboration based on the findings. Finally, to aid in knowledge translation, the researcher created a one-page summary of the recommendations for transformative action (see Appendix A) to provide a concise summary of the implications of the study for relevant decision makers.
3.7 References


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Chapter 4: Findings, Discussion, and Recommendations

4.1 Participant Demographics

After obtaining ethical approval, eight participants (four female and four male) across two Ontario Schools of Nursing were interviewed throughout the study. Participants identified as Indian, Japanese/British/Irish/Canadian, Ojibwe, Latino, Iranian/Canadian, South Asian/Indian, East African/Maltese/Greek/Mediterranean Portuguese and South Korean. Two participants shared that they were international students, and one identified themselves as a first-generation immigrant and first in his family to go to university. Participants included individuals in the second, third, and fourth years of their respective nursing programs. Two participants identified as belonging to middle class families and one participant identified as gay.

4.2 Findings

From the hand-coded data, five high-level themes were developed. These included: (a) Belonging as a Determinant to Student Learning, Retention and Patient Safety; (b) Minoritized Identities on Display: Discrimination Threatening Clinical Belonging; (c) How Power Dynamics at the Interpersonal and Institutional Levels Silence Students from Addressing Discrimination in the Clinical Environment; (d) “We Take it Seriously”: How the Representation of Minoritized Identities Influences Students’ Sense of Belonging; and (e) How Nursing Students’ Identities Intersected to Influence their Experiences of Belonging During Clinical Placements. In theme one, the positive outcomes of belonging on participants’ clinical learning is reviewed and the factors such as personal values that informed these experiences of belonging are highlighted. In
themes two and three, the negative impact of discrimination on participants’ sense of belonging is identified, and the structural barriers that reinforce these experiences are illuminated. Theme four highlights how the representation of minoritized identities impacted how participants navigated experiences of belonging and discrimination. Finally, in theme five, participants’ accounts provide insight into how their experiences of belonging were informed by their unique intersectional identities and the dominant values within Canadian culture.

4.2.1 Theme #1: Belonging as a Determinant to Student Learning, Retention, and Patient Safety

Participants’ sense of belonging within the clinical unit changed frequently from shift to shift or clinical placement to clinical placement based on their day-to-day experiences. All of the participants described moments that made them feel like they didn’t belong on the clinical unit. Participants described a wide variety of feelings associated with not belonging including frustration, irritation, anxiousness, stress, anger, sadness, and feeling alienated. In one instance, a participant described how their feelings of not belonging during their clinical placements left them feeling under so much pressure that they felt “numb”. As a result of not feeling a sense of belonging during clinical placements, some participants described “dreading” going to clinical, not wanting to be at the clinical placement and taking opportunities to leave early when possible. In the example below, Naveen describes how feeling as if he didn’t belong made him want to leave clinical and negatively impacted his motivation to learn:

Naveen: A huge priority, you know, that's, that's one of the worst things, right? Like being in a room that's why I said like, that's the worst feeling like being in a room full of people and you don't you feel like you don't belong. It is very nerve wracking. So being in a class, I feel like if you don't belong, if you don't feel like you belong there, you're not going to study, you're not going to learn, you just
constantly, you just want to get out of there. So sometimes in clinical settings that's all you want to do is just, you know, get out of there, you're so awkward, your heart is pounding, you're just so stressed out. Just being there for an hour just takes a year off your life because you're just so stressed out. So yeah, it's very very important for you to feel belonged.

Others described how feelings of not belonging would change their behaviors in ways that would negatively influence their learning. Participants described attempting to avoid patients and nurses who made them feel as though they didn’t belong, would choose to take an observing role instead of engaging in patient care and would no longer feel comfortable asking questions to further their own learning. In the example below, Penelope was prompted to explain why being told she was asking too many questions negatively impacted her experience of belonging, and described how she felt she had to modify her own learning behaviors in order to belong:

Penelope: I think you know I ask questions because I’m trying to further my own knowledge. I'm trying to become a nurse who is competent and asking questions is part of my learning process to be able to get there, and so I would think that someone who's asking questions would be viewed as someone who's engaged in their own learning. Someone who's interested and wants to improve, and you know, I would have thought that that would have been encouraged … When I'm told sorry that you know I’m asking too many questions. It makes me wonder what's the limit on the number of questions that I can ask in order to not be told that I'm asking too many questions? It makes me wonder why they may want someone who doesn't then have the knowledge or have the understanding in this profession. It doesn't make sense to me and it's like because of my cultural upbringing, I go to a place of okay, so how do I fit in? How do I, how do I modify my own behavior in order to ask fewer questions, and not be seen as someone who's disrupting the space?

In contrast, many participants described clinical environments in which they felt a sense of belonging and the positive impact it had on their learning. Clinical environments where participants felt welcomed, valued, accepted, and supported positively influenced their sense of belonging. Clinical instructors and co-caring nurses who were perceived to be invested in student’s learning positively influenced students’ sense of belonging.
Participants described that clinical instructors and co-caring nurses showed they were invested in student learning by providing students with learning opportunities, encouraging them to get involved in patient care, and assessing their learning needs. As a result of feeling this sense of belonging, some participants described being excited to come to placement, feeling more comfortable asking questions to facilitate learning, and felt they were able to improve their confidence and provide their best care.

For many participants, the relationships that informed their sense of belonging and learning were influenced by whether their personal values aligned with those of their colleagues’. Some participants shared how their personal values didn’t align with their colleagues within the clinical space and discussed how that negatively impacted their sense of belonging. In the example below, Penelope describes how disagreeing with the values of her co-caring nurses’ approach to care negatively influence her sense of belonging.

Penelope: I had a co-caring nurse one day who was a very experienced, had 20 plus years in nursing co-caring nurse, and you know, we had a difficult shift where not everything was going the way, not everything was going as planned. And there were some things that came up that we had to deal with. And it wasn't by any means an easy shift. And you know I think there is an element of like I get the difficult shifts happen and I understand that you know nursing isn't easy every day, it's really not. But I think that the way that that nurse handled some of the things that they did, and the comments that were made to me about nursing and about you know some patients that day, it doesn't, it makes me wonder whether I do belong in nursing, because I had very different views than that nurse did on what was happening that day, and why things were happening the way they were, and the way that I thought that they should be dealt with. And I defer to them because they have 20 years of experience and I’m just the student learning. But at the same time there were some, maybe assumptions made about the patients, and some assumptions made about, you know, about the way that I was handling things as a student that made me question if this is the way that they're teaching me, and this is the way that they want things to be done and I have very different views on how I think things should be done because I just have different values as a person in general, do I belong here?
When prompted to provide examples of how her personal values differed from her co-caring nurses’ values, Penelope described a situation in which her co-caring nurse denied providing care to a client based on the assumption that client wasn’t fulfilling their personal responsibility to take adequate care of themselves at home.

Penelope: We had a patient that was not taking good care of themselves at home for probably a number of different reasons... and the co-caring nurse that I worked with viewed that patient that day as being very demanding, asking for any number of different things and saying [speaking as patient] “No, I don’t want this, I want that instead”… And I viewed that as if these are things that would make this patient feel more comfortable being in an unfamiliar hospital environment when they are already not feeling well, and you know it’s a small thing for me to provide something, I mean I would have to figure out where to get that resource... And this co-caring nurse was not willing to do that because they viewed it as demanding and they viewed it as, [speaking as co-caring nurse] “well, this person wasn’t taking good care of themselves at home”, and there were some assumptions made by the co-caring nurse about why that was, even though we had no idea why that was... It wasn’t my place as a nurse to pass judgment on how they were conducting themselves in their home environment, and reuse that judgment to then justify delivering or not delivering care when they were in the hospital environment, when I was responsible for delivering care. So, my values on that are very different than the co-caring nurses' values on that.

For participants who were international students, they discussed how they found Canadian culture to be very individualistic. They discussed how coming from upbringings that were more collectivist or community-based made it difficult to belong because they didn’t share the same values as many individuals who grew up in Canada.

In the example below, Phil describes how his unique worldview and life experiences made it harder for him to belong than others:

Phil: Just the way you think, just your worldview is so much different. And also having lived in 3 continents, and you know, just meeting a bunch of people from different backgrounds, and I guess your brain is somewhat expanded a lot more than people from here. Because a lot of them, you know, for example, they’ve only lived in [mid sized city] their whole life, or only in Canada for example, which is, you know, very fine, which is absolutely fine. But from a perspective like me, who I guess has lived kind of everywhere and just has a little bit more of a diverse experience, it could be hard to, you know, really share, or to really have
that close connection because of the different backgrounds and just the way you see the world.

On the other hand, Kal described having a shared value of teamwork with the other nurses he worked with on the unit. When asked if this impacted his sense of belonging at all, Kal shared that it had a positive impact.

Kal: Yeah, because we kind of share the same kind of values, right? We share the same approach to our nursing care. This is not just a me thing, we have to collaborate on some things and try to help each other out, right? Like yesterday two of our patients got discharged right, so our load got smaller, so we could help out more people, right? So we weren’t like, oh no our patients are like taken care of, we don’t need to help anybody else out we’re just sitting around, right?. It’s not like that. It’s like we’re helping out other people, because we have time, right?

In addition to the impact that belonging had on learning, multiple participants alluded to how not feeling a sense of belonging on the clinical unit made them question whether nursing was the correct career option for them:

Penelope: It would be nice. It would be so nice to walk into clinical environment or work environment and feel like I belong every single day. That would be awesome, because that would be something that would keep me in the field of nursing. But I can't sit here and say that I will stay in nursing forever if nothing changes.

Kal: I just couldn’t think straight and then that made me question at some point whether or not I was doing, I was in the right place at the right time, you know, with my potential career.

Participants’ sense of belonging also had implications for patient safety. In one instance, a participant described how belonging provided them with the self-confidence they needed to speak up to a co-worker when they witnessed malpractice. In the example below, Kal discussed how his sense of belonging made him more comfortable to ask questions. He described how when students don’t feel comfortable asking questions, they are left to provide care without all of the information required to perform tasks safely.

Kal: I think [belonging] is like one of the highest priorities right next to patient care, because you can't have patient care without collaborative care, right? If I
don't feel comfortable enough talking to a surgeon about a patient’s post-op assessments, then how am I supposed to care for that patient, right? If I don't feel like I can ask a nurse if I can push an IV med even though I’m able to, like if I don't think it's a good idea and I can’t consult with somebody else about it, then I’m making decisions with, like it's very risky at a certain point. So having that sense of belongingness and being able to reach out actually affects the way I would care for patients like a lot.

4.2.2 Theme #2: Minoritized Identities on Display: Discrimination Threatening Clinical Belonging

The negative impact of discrimination on nursing student’s sense of belonging on the clinical unit was a common theme among participants. Many participants described encountering or witnessing acts of discrimination during their clinical placements that negatively influenced their sense of belonging. Perpetrators included all individuals involved in the participant’s learning including clinical nursing instructors, the nurses or personal support workers working on the unit, other student nurses and the patients they cared for. Some participants described how they felt as though their instructors perceived them to be inferior to their white peers, or that they had to work harder than their white peers to be heard or acknowledged. Others described being treated differently on the basis of their appearance or gender, frequently being asked questions about their racial or ethnic identity or having some aspect of the cultural identity denigrated. Additionally, participants described how witnessing discriminatory acts directed towards other racialized individuals in the clinical environment negatively influenced their sense of belonging. As Penelope describes below, these discriminatory acts could be experienced on the clinical unit quite frequently and directly influenced whether she felt a sense of belonging in the clinical environment, or to the nursing profession.

Penelope: I've been in clinic 15 days total so far, and I've had 5 different experiences where someone asked about my culture, my heritage, my last name… or even my appearance. And so, when someone does that it, it does make me question whether or not I belong in nursing and whether or not I belong in that
clinical environment in the position that I am as a student nurse… I certainly question whether some of my other white or white passing classmates get questions like that. And so, and I also find it fascinating because we're all in masks. And so, you can only see this part of my face, and I still get asked those questions. So, without being asked those questions, I would say, yeah, I probably feel like I belong in nursing. And when I get asked those questions, I would say no I don't really feel like I've that I belong in nursing.

Penelope later went on to elaborate why these comments impacted her sense of belonging and identified that her experiences with discrimination made her question whether she was capable of ever feeling a sense of belonging in the field of nursing:

Penelope: Every one of those chips away at my belief that I belong. It chips away at my belief that I will ever belong, because it makes me wonder if things will ever change to a point where I do feel like I belong, and I can, you know, reach my full potential in this field. I again, each one of those is a reminder that I'm different. And it's not necessarily that encouraging or leading in the direction that that difference is a strength. It just points out a difference and so without then the second half of acknowledging that that difference in perspective or difference in experience might then help to positively impact nursing, it's just left as a hole poked without a patch put on.

For Carlos, he described how having a supportive clinical environment in which he could approach others for support after experiencing an act of discrimination was integral for him to experience a sense of belonging on the clinical unit. However, Carlos describes a discriminatory incident directed towards him and highlighted how he felt there were very few people he could approach within the clinical environment who would deal with his concerns seriously.

Carlos: I had this one patient I remember who basically was kind of like badgering me. He’s like, hey you're Latino so obviously there’s gotta be some woman in your community or in your family who does house cleaning work or like kind of maid service, whatever. I just need someone to come over to my house and clean up. I’m like, I don’t know anyone. Anyone that I know who would’ve done stuff like that, they’ve moved on from it years ago. And he constantly badgered me like, no, no you’re Latino, you obviously know somebody. Well, no, I don’t. And just trying to figure out kind of how to navigate that type of situation. Also having some of my classmates telling me, like one of them wears a hijab and she was telling me that, she came to me [saying], I have no one to talk to about this, because I had someone tell me you don’t even belong
in this country, I don’t want you taking care of me. So, my general feelings with it are that it is very limited in who you can go to talk to about things because not everyone is going to listen, and those who do listen, not everyone is going to take it seriously.

The quote above reveals that some students may feel unsupported or unheard when attempting to approach nurses or mentors to address acts of discrimination within the clinical environment. One participant described not knowing the proper channels to address discrimination in the clinical environment. As the following theme will highlight, participants faced numerous barriers when attempting to address the discrimination that negatively influenced their sense of belonging.

4.2.3 Theme #3: How Power Dynamics at the Interpersonal and Institutional Levels Silence Students from Addressing Discrimination in the Clinical Environment

Many participants described various reasons they chose not to address discrimination within the clinical environment. Multiple participants identified how they felt powerless in their role as a student on the clinical unit to address the acts of discrimination that negatively impacted their sense of belonging. As seen in these first examples, unequal power dynamics between student nurses and their nursing mentors on the clinical unit hindered participants from addressing the acts of discrimination they encountered in the clinical environment:

Mary: I feel like as a student we don’t have the power to call them out. Like, and even if we did like I feel like the co-nurse could just deny it because there’s no real proof if they made like a weird statement.

Penelope: I’m still, very well aware as a student of the power dynamic that instructors have over my marks. Which are important to me considering I may not be done school after I finish this program, so these marks then will affect how or where I apply for other further schooling. So, my marks being very important to me, I’m trying not to do anything that would disrupt that.
Some participants also noted how they were worried that addressing discriminatory acts might create an awkward situation with perpetrators on the clinical unit, and instead often chose to remain silent. Participants described how they were fearful that in the event that addressing an act of discrimination created an uncomfortable relationship between them and the perpetrator, that they would have to continue work alongside them or see them during future shifts. As the examples below highlight, participants also chose to avoid addressing discrimination due to fear of personal consequences such as loss of academic standing, fear of reprisal, and to avoid “rocking the boat”:

Penelope: Part of me wonders whether or not it would be beneficial for people to know every time they express a microaggression… Would that then mean that there’s backlash to me if I point that out to my co-caring nurse? Does that then mean they tell my instructor that I’m difficult, that I’m hard to work with? That, you know, I’m not a good student nurse? Maybe? Right? So some of those things pulled me back from pointing that out every time it happens to me.

Maggie: Right now I’m at the bottom of the food chain in like the nursing world… I’m just terrified of what they’re going to think of me. I’m terrified I’m going to start something huge. I’m terrified that like they’re gonna like say something back or like make me feel really bad inside and I don’t want to go back to the hospital setting and have to deal with that person again.

Carlos: In placement, there is that power with your co-caring nurse and trying to make sure that you’re doing a good job. And you don’t want to rock the boat too much… But it’s also we’re in nursing. So you don’t want to do something that’s gonna harm the patient either. We’re always trying to make sure that they’re taken care of. And I think part of it is like if you gotta take it on the chin in order to make things run smoothly, then I might decide to do that instead of rocking the situation too much.

Others described the power that the larger institutions of the hospital and university had in shaping an individual’s sense of belonging. As Penelope describes, the values espoused by these institutions can influence the worldviews of individuals and consequently shape the clinical environment in which people seek to belong:
Penelope: I think that the establishment of a university and the education that they provide, the courses that they provide, the views that the instructors have, those all influence what we learn and that then influences how people can then choose to incorporate or not incorporate that knowledge into their own or those perspectives or into their own worldview. And so, I think that certainly the educational establishment of a university, holds a lot of power over someone's sense of belonging. I think that even a hospital environment, the hospital values and the values that people in society have and bring to work with them every day, that influences.

Examples of the influence of policy on nursing student’s sense of belonging can be seen in the experiences of Jasmine and Phil. For Jasmine, there was one particular clinical placement in which she felt like she belonged more than another. When asked to identify if there was anything specific about that placement that made her feel like she belonged, she described the positive impact of a hospital policy:

Jasmine: They brought the like student coordinator of the facility into the orientation to speak with us. And so, she spoke about some of the like hospital policies, and what they do. And so, one of their one of their policies for, like, organizational culture from, like, between staff as well as staff and visitors and staff and patients. Like I think it's called the [hospital policy]. But it's basically like to create a culture in the facility where people aren't, like you're encouraged to engage with people... So when you're passing people in the hallway like make eye contact and smile. If you see someone kind of like looking a little bit lost, rather than just telling them how to get somewhere, take them to the place where they can get to the place. So, there were things like that that I don't know I really enjoyed.

In contrast, when asked if there were any additional factors that influenced his sense of belonging on the clinical unit, Phil described how a policy in which he wasn’t allowed to carry his phone made him feel unsafe in clinical spaces based on his prior lived experience:

Phil: Back when I was in twelfth grade, there was a group of terrorists that came to our school with guns and back then the policy was that you’re not supposed to have your phone with you. But if I had my phone, you know, I would at least, you know, take videos of them secretly or call for emergency or something like that. I know in the hospital it’s that you’re not allowed to have your phones. So, even though I guess it’s way safer than [Central African Country], a lot of certain
things like that could trigger and you know really bring those traumatic memories.

One participant commented on how the education provided by his academic institution may influence the actions of his peers. In the example below, Carlos described how a gap in his nursing curriculum might influence how his peers support him in the moment that a discriminatory act occurs:

Carlos: We’ve spent so much time going over fundamentals, going over therapeutic communication, going over how to deal with the patient and not discriminate against them and blah, blah, blah, blah, blah. But at no point in time in lab and sim or anywhere did we ever talk about when things are directed towards us... Overall, it’s a pretty homogenous program and it kinda makes me wonder sometimes, if I had a classmate in that room, would they have said anything, yes or no? And without having that conversation beforehand, I don’t know if any of them would’ve said anything if I myself wasn’t going to say something or wasn’t sure as to how to respond. So, I feel like it’s a gap in our curriculum that we don’t address it.

Finally, in the examples below Carlos described feeling unsupported when attempting to bring up his experiences with discrimination with faculty directly during organized school meetings, and highlighted the power that the university had over him by having the choice to address his concerns or not:

Carlos: Outside of clinical placements, I’ve brought up these concerns with the school because I have been a part of [nursing student group] all throughout my time here in nursing school. And I brought up concerns during [nursing school event] during my very first year and my concerns were not even brought up. Because the way we did it that year was that everyone put in their concerns, the concerns are forwarded off to the faculty, and the faculty has a chance to review the concerns, so they have answers prepared when the [nursing school event] actually happens. And those things were not even brought up.

Carlos: When it comes to like bringing it up with school directly, there is that power dynamic. Like I mentioned before they can choose to listen to me or not. They can choose to provide an answer, they can choose to address it. Whereas I just have to be on the receiving end of everything that might happen.
4.2.4  Theme #4: “We Take it Seriously”: How the Representation of Minoritized Identities Influences Students’ Sense of Belonging

Many participants discussed how their sense of belonging was influenced by whether or not other racialized or minoritized individuals were represented among their, peers, patients, clinical instructors, or nurses on the clinical units they worked. Some participants described how seeing individuals who looked like them, or who had similar life experiences working as nurses improved their sense of belonging because it made them feel less different and made them more comfortable on the unit. In the example below, Naveen describes how having clinical instructors of different backgrounds sharing their lived experiences would help him feel like he belonged in the clinical setting.

Naveen: If like a little bit of [clinical instructors] would be a different background maybe immigrants. It doesn't have to be just immigrants, it can be like Canadian people of color, immigrants, you know have that little bit of a mix or Indigenous people talking about their community, like their lived experiences in like reserves so you know you have that first hand experience of that knowledge, that is that something that would help me for now to, you know, feel belonged.

Others discussed how they would be more willing to approach a racialized instructor for support after the discriminatory acts that negatively influenced their sense of belonging because they felt they would be more likely to listen and take the concern seriously. In the example below, Carlos describes experiences in which he felt racialized faculty were the only individuals that he felt actually addressed his concerns:

Carlos: And even in those [instances of discrimination], the only people who addressed it, were the people of colour. An example, [instructor] who is the one from [school], she brought it up, she addressed it. [Other instructor], she’s also had these conversations with me before as well. And that’s why to me it’s really important that we have more representation because these people actually take this stuff seriously. And I think I generally come on with the feeling that if it's not making you feel uncomfortable, you’re not going to care about it. But those of us who have felt uncomfortable, we are going to address it, we take it seriously.
Some participants described how navigating homogenous clinical spaces made them feel uncomfortable or that they had to work harder to feel connected to the team. For Naveen, he discussed how he felt uncomfortable in clinical spaces that were predominantly white. These feelings were informed by his daily lived experiences with discrimination.

Naveen: I'm going to put it bluntly I don't like the fact that all our clinical instructors are white. I just don't… I tell my partner who's white like we don't live in the same world. We live in the same world, but we don't live in the same world at the same time. So, me going to a bar or like a social setting with a lot of Caucasian background makes me uncomfortable because I am from, like I said, the cultural climate right now, I have to be more careful. I don't feel safe because that's my back. I've been thrown stuff at, I've been said things, I've been called names so I'm uncomfortable indirectly. Like I'm comfortable talking to you right now, but in a clinical if I'm in a setting with like 10 white guys and I'm sitting there, I'm not comfortable.

For others like Maggie, when prompted to discuss how the representation of racialized clinical instructors might impact her experience of belonging, she described how learning from a role-model that has shared experiences as a minoritized individual would improve her comfort and learning in the clinical space:

Maggie: I think [representation] is very important, because once again like I’m looking up to the clinical instructor, I want the clinical instructor to kind of like be like me. And it doesn’t have to be exactly like me, but I want them to know, because a white person, a white clinical instructor is never going to get it, you know? And as much as they say they do, they don’t know until they’re in my position. So, I feel like it would be nice because I feel like if someone like the same, like even if they’re like Asian, or Black or something, I feel like they would get it because they’ve been through the hardships. I feel like they would be, like, I could like comprehend and understand them more when they talk or something or do actions, because I feel like I can do that too.

Maggie: I think it would make me feel more welcome, because they would hear me out more and give me like a chance to talk. And I wouldn’t feel as judged, or like I wouldn’t feel as like worried.
4.2.5  Theme #5: How Nursing Students’ Identities Intersected to Influence Their Experiences of Belonging During Clinical Placements

Many participants discussed how their unique intersectional identities influenced their experiences of belonging during their clinical placements. Participants who were both racialized and international students including Phil and Naveen described difficulties finding a sense of belonging while navigating Canadian culture. In the examples below, both Phil and Naveen described how they felt that they didn’t share many of the same values or background as individuals who grew up in Canadian culture and how that made it uniquely difficult to belong.

Phil: All my life I’ve always been around with people that were you know from Korea or from [Central African Country]. Also, American and some Canadians, but they also were missionary kids just like me. So, there was that difference from, you know, 100% Canadian or 100% American. When I come here nobody had that kind of background, and also specifically in nursing there's really not many international students. So [I] did feel kind of alienated and intimidated at first. Also, the culture is, you know, you do your own thing. You have your own classes, and I was used to, you know, small communities. Everybody knew each other, but not here.

Naveen: So, when I went to [college] for two years, everyone that I went to school with were white, the entire class. So, at that point I wished somebody looked like me because I felt, you know, not different. It’s like looking at everybody right and there’s a spot of brown skin there, that made me really uncomfortable. By going here to nursing, we do have that cultural differences as in like visibly you can see different colors, but they are very much of, you know, Canadian culture. So, it’s very difficult to explain the feeling like I know you kind of, you look like you belong there, but at the end of the day you don’t, because I’m an immigrant at the same time.

Others commented on how their gender and race intersected to influence their experience of belonging. One participant identified how being a racialized male made it difficult to belong because there were multiple aspects of his identity that was different from the majority. Other participants commented on how they found being a racialized male advantageous to experiencing a sense of belonging. Carlos commented on how he
believed the discrimination he faced from patients that negatively influenced his sense of belonging may have been less common and less explicit because he was male. In the example below, Naveen discussed how a competitive culture among female staff within his working area provided easier access to belonging as a racialized male:

Naveen: Being a male is a little bit more helpful and it’s a little bit of an advantage to me at this point. Just because I feel like when I, when I go to placement, I have an easier time than female students. So, I can only imagine what like a person of color who is also a woman goes through... I feel like there’s a lot of competition within the community... People say [for example] oh, I’m glad that there’s not just another female staff working and I like to have that balance.

On the other hand, some female participants identified that their sense of belonging was informed by being in a profession where the workers are traditionally female. In the example below, Jasmine described how working in a predominately female environment informed her sense of belonging:

Jasmine: You are quite aware of the difference in proportions of nurses to male nurses. And even when it comes to the administrative roles in nursing, definitely more female representation than males. ... even our clinical instructors, I’ve definitely heard of more female clinical instructors than male clinical instructors. Yeah, so I definitely think that being a woman would be more advantageous to like a feeling of belonging, because nurses are traditionally more commonly female.

For Naveen, his sexuality and ethnic heritage also intersected to inform his experience of belonging. When asked how his sexuality informed his sense of belonging, Naveen described how he hid aspects of his identity to avoid awkward conversations with co-workers and feel normal:

Naveen: If somebody from [country of origin] is working there and I say that I’m gay that creates an awkwardness because you know being gay is something frowned upon still in [country of origin]. So, I feel like when I work with somebody, I have to hide that part of my identity to be normal.
In contrast to Phil and Naveen’s experiences as racialized international students, other participants who experienced discrimination reflected on how being racialized individuals who grew up in Canada made it easier to belong within the clinical space because it made it easier to get along and connect with others:

Interviewer: Do you think that there’s any other aspects of your identity that might have impacted your experience of belonging in this particular situation?

Carlos: Maybe moreso that I’ve grown up here. So, I don’t have, sorry, I did pre-health too before I went into this program. So, I met a lot of friends in pre-health who were international students… and they have very noticeable accents and they’ve had experiences as a result of it and I know I’ve mentioned this with quite a few students who come from India as well and the exact same experiences that sometimes it’s a little more difficult for them for that. And I don’t have to deal with that because I’ve grown up here, I’ve learned English here, I think I’ve kind of benefitted.

For others like Penelope, they described that although there were moments in which the discrimination she received as a racialized female made it harder to belong, that there were many privileged aspects of their identity that intersected to make it easier to belong:

Penelope: I have a fair amount of privilege as a cis, sometimes white passing person. And even again, woman in female dominated nursing. Yeah, I carry a certain amount of privilege with that. I carry privilege as a settler in this country that my indigenous counterparts do not. And even as a middle-class citizen I carry privilege with regards to, you know, resources that I have that have been available to me to be working, to pursue my education, to be able to live safely in the community and to have, you know, adequate shelter, food, water, all of that. I also carry privilege when it comes to the amount of education that I’ve been able to pursue in my health literacy because of that. And so yes, I think that absolutely I think my positionality with regards to that has benefited me in a sense of belonging when it comes to all of those things as opposed to someone who maybe doesn't identify as cis gender doesn't identify as white, or white passing doesn't or perhaps is indigenous or any of the other, even having English as a first language is another, you know, aspect of my privilege.
When prompted to discuss why these aspects of her identity made it easier to belong, Penelope identified how these “privileged” aspects of her identity aligned with the “majority” of the Canadian population.

Penelope: I think that those make it easier because I’m part of the majority. I’m not part of the minority in some aspects. And so, in lots of those aspects, and so you know I’m not pointed out for being different for some of those things. And I have not had to face backlash for a lot of those things. And so that has certainly made my path a little bit easier. Could it have been easier than it has been? Sure. Of course, it could have been. But in comparison to what other people are experiencing, yeah, I have, I face some microaggressions, but it’s a whole lot easier than it could be.

Finally, a few participants spoke about how their experiences of belonging as racially minoritized individuals who were white passing differed from other individuals with minoritized identities because they were less likely to be subject to discrimination:

Interviewer: You’ve talked a little bit about the fact that you mentioned you’re racially ambiguous. Could you talk about how your identity makes it easier or harder to belong compared to other people?

Mary: So, like, just like compared to my family members like I have pretty fair skin, or just compared to people in my community I have very fair skin. And I think that kind of like, that is actually like it’s called white passing privilege. I don’t know if you’ve heard of it. Basically, like I have parents that conform to like these Eurocentric standards more, and that gives me a privilege. So, like my brother and my dad and my grandpa for example like they tend to have brown skin and they have dark hair, and my grandpa wears a turban, my dad has an accent… they have like, way more different experiences that I do on their day to day. For my brother, it’s often assumed that he is stealing things… I don’t really have the experiences that they do.

Jasmine: I feel because I’m white passing a lot of if I don’t feel like a sense of belonging to an area, it is, it does seem a little bit more internally driven in that I feel my otherness, as well as see things through my own lens that others might not be aware of.

4.3 Discussion and Recommendations

The purpose of this interpretive descriptive study was to obtain an in-depth understanding of how racially and ethnically minoritized baccalaureate nursing students
in Ontario experience a sense of belonging during their clinical placements. The researcher attempted to answer the following research questions: (a) What are the experiences of belonging during clinical placements among nursing students with racially or ethnically minoritized identities in Ontario mid-sized cities? (b) How do systems of power influence sense of belonging during clinical placements among nursing students with racially and ethnically minoritized identities? and (c) What are the factors that influence sense of belonging during clinical placements among nursing students with racially and ethnically minoritized identities? In this section, I start by highlighting how the findings reinforce arguments that have been made in prior scholarship about the importance of investing resources to improve students’ experiences of belonging during their clinical placements. Secondly, the themes developed from the findings collectively illustrate the discriminatory structures that negatively impacted participants’ experiences of belonging. Thus, the findings and recommendations within this section will be placed within specific domains of action that aim to dismantle student barriers to belonging. A summary of the recommendations developed for the purpose of knowledge translation can be found in Appendix A.

4.3.1 Sense of Belonging: A Critical Facet of Clinical Nursing Education

The words of the eight participants highlight how racially and ethnically minoritized nursing students experience a sense of belonging while navigating discriminatory clinical environments. The findings from theme one support what has been found repeatedly in the extant literature. Specifically, that belongingness is integral to nursing students’ learning during clinical placements (Albloushi et al., 2019; Honda et al., 2016; Levett-Jones & Lathlean, 2008; Kern et al., 2014), and has positive
implications for patient safety (Levett-Jones & Lathlean, 2009; Honda et al., 2016).

Participants described how their sense of belonging directly influenced their motivation to learn, comfort in asking questions, willingness to take an active role in patient care, and their confidence to address malpractice. Clinical experiences are crucial in allowing nursing students to develop the knowledge and skills required to become effective nursing professionals (Flott & Linden, 2016; RNAO, 2017). Given the integral role that belonging plays in students’ learning process, it is imperative that hospitals and Schools of Nursing invest resources to develop strategies to promote student belonging within the clinical environment. Some participants’ responses suggest that the importance of belongingness may be overlooked within some Ontario Schools of Nursing. For example, one participant who identified clinical belonging as a “huge priority” for him, reflected on how discussions of the concept had never been discussed in any of his nursing classes. Another participant explained how her experiences of not belonging remained hidden because no formalized systems existed within her school to address her experiences of belonging during her clinical placements. Thus, as a first step, I encourage academic institutions to develop formalized structures for students to provide feedback on their experiences of belonging. Student feedback may provide an effective means of identifying barriers to belonging, as well as priority areas for interventions designed to improve students’ sense of belonging.

4.3.2 Develop Belongingness Interventions That Recognize Individual’s Nuanced Experiences of Belonging

The findings from this study also illustrate the intersectional nature of participants’ experiences of belonging on the clinical unit. This was particularly evident in the accounts of international students in this study. Two participants described how
their position as both racialized individuals and international students intertwined to make it uniquely difficult to find spaces in which they felt they could belong. For example, one participant who described being more comfortable around other racialized individuals also described feeling “stuck between two cultures” where being a racialized international student informed feelings of difference that made it difficult to fit in with racialized individuals who were raised in Canada, as well as other international students. Edgecomb and colleagues review of the literature (2013) has previously highlighted the numerous barriers international nursing students face that may cause them to experience feelings of alienation when navigating new pedagogical cultures. Their findings suggest that little work has been done to support international students in their clinical learning. Edgecomb and colleagues (2013) concluded that finding strategies to overcome barriers to creating authentic connections within their new academic environment was imperative. The insight from this study offers direction for individuals looking to engage in transformative work aimed at improving nursing students’ sense of belonging. Namely, that a one-size fits all approach to improving students’ belonging will fail to recognize the complex nature of students’ intersectional experiences of belonging (Strayhorn, 2019). As argued by Strayhorn (2019), belongingness interventions that rely on singular solutions are ultimately “doomed to fail”. Participant’s experiences highlighted how their sense of belonging was seldom informed by only one particular factor or aspect of their identity. Instead, their experiences of belonging revealed how various aspects of their identity (i.e. race, gender, sexuality) intersected to create unique barriers and privileges (often simultaneously) to experiencing belonging. These experiences were further shaped by a network of other forces such as their interactions with peers and mentors, the
pedagogical practices they encountered, and the values espoused by the institutions they navigated. Thus, interventions designed to address student’s sense of belonging must recognize students’ experiences as intersectional and prioritize multi-faceted strategies that address the numerous forces that act as barriers to student belonging. Unfortunately, as detailed in the next section, there is little literature that supports the effectiveness of any specific intervention aimed at addressing the structural barriers to nursing students’ sense of belonging within clinical environments.

4.3.3 Promote A Diverse Nursing Workforce by Improving Experiences of Belonging

In chapter two, it was argued that interventions to improve nursing students’ sense of belonging were crucial to support a capable and diverse nursing workforce, amidst a global nursing shortage. It was also argued that ensuring a diverse nursing workforce was important to facilitate culturally competent care, cultural safety, and access to care for marginalized groups (Jeffries et al., 2018). The results of this study support the initial argument presented in this thesis that investing in interventions that address structural barriers to student belonging may be an effective means of retaining racialized students within the nursing profession. Some participants described how experiencing a sense of belonging would directly impact their decision to stay in the nursing profession. Previous work by Borrott (2016) also concluded that a sense of belonging within clinical placements could be a factor in the retention of nursing students by increasing their workplace satisfaction. However, to the researcher’s knowledge, this is the first study to suggest that a sense of belonging may directly contribute to the retention of racialized individuals within the nursing profession. Working alongside colleagues and patients who accepted them made some participants feel valued and provided impetus for
participants to return to placement each day. In contrast, discriminatory clinical environments prompted some participants to question whether they could work or belong in a nursing profession where their intersectional identities were problematized and made to seem inferior. From the review of the literature presented in this thesis, it appears that no research exists exploring the effectiveness of any specific intervention on nursing students’ sense of belonging within clinical environments. However, in the broader higher education literature, belongingness interventions have been successful in improving the retention of racialized students in higher education (Murphy et al., 2020). In the context of a global nursing shortage, it would be valuable for future research to explore the impact of specific interventions that target the numerous structural forces that influence racialized nursing students’ sense of belonging within clinical spaces.

4.3.4 Address Discriminatory Structures Within Clinical Placement Settings

Participants’ accounts also revealed how the normalized dominance of Whiteness in clinical spaces shaped their experiences of belonging. Participants described how individuals who possessed identities and worldviews that did not reflect the “majority” within clinical environments were discriminated against, problematized, questioned, or were frequently made to be reminded of their otherness. For many of the participants, discriminatory experiences and differential treatment made them feel as though they didn’t belong on the clinical unit or to the nursing profession. While some participants identified how aspects of their identities (i.e. race and gender) intersected to shape these discriminatory experiences, others described how their self-identified white-passing privilege provided easier access to belonging within clinical spaces. The privilege of Whiteness within Canada is the product of the historical impact of colonialism that
centered European (White) values within Canadian society. Whiteness has also been central to the inception of the nursing profession in Canada. The historical exclusion of racialized individuals from the profession and efforts to depict nurses within the lens of Victorian ideals of femininity positioned Whiteness and Eurocentric ideals as central to the profession (Flynn, 2009). Within the study, the lack of representation of racialized individuals reinforced Whiteness within clinical spaces by positioning racialized identities as a deviation from the norm. Some participants felt white instructors and co-caring nurses saw them as inferior to their white peers and that they had to work harder to be acknowledged. In order to improve their chances of belonging, other participants discussed hiding or changing some aspect of their racialized identity. These findings illustrate that the normalized dominance of Whiteness within Canadian nursing may act as a systemic barrier for some racialized nurses to experience a sense of belonging to their professional role.

Through the second research question, I sought to explore how systems of power influence participants’ sense of belonging during clinical placements. What was revealed was the power dynamics that frequently silenced nursing students from addressing the discrimination that negatively influenced their sense of belonging. This silence was perpetuated, in part, by the disempowered position that participants occupied as students. Preceptors and clinical instructors possess a large degree of power and control over students’ clinical learning. They also have power in dictating whether students are ultimately successful in their clinical course. This uneven power dynamic made students reticent to address experiences of discrimination in the clinical environment due to fear of personal consequence. What was further revealed was the absence of support participants
received from the individuals and institutions who were well positioned to address discrimination. When participants did choose to seek support from those in positions of power, they were frequently ignored or dismissed. In keeping with the results of this study, other researchers suggest a culture of silence around racism exists within the nursing profession that functions to perpetuate discriminatory clinical environments (Beagan et al., 2022; Iheduru-Anderson et al., 2021). Ultimately, when discrimination is not challenged or individuals’ experiences are silenced, the impact and incidence of discrimination remains largely hidden and unchallenged. Thus, it is reasonable to assume that the discriminatory clinical spaces found within this study will continue to persist without the implementation of institutional structures and processes that directly address students’ discriminatory experiences. The Ontario Human Rights Code dictates that institutions have an obligation to ensure that students are able to navigate clinical learning environments that are free from discrimination. Based on the findings of this study, I argue that there is an urgent need for nursing leaders within Canadian Schools of Nursing and healthcare institutions to fulfill this obligation through the implementation anti-racist interventions within clinical placements. This argument is supported by the recent declaration put forth by numerous Canadian nursing organizations advocating for the implementation of anti-racist and anti-oppressive interventions within Canadian healthcare institutions (Canadian Nurses Association, 2021). These interventions are needed to prevent discrimination and promote a greater degree of inclusion for racialized individuals in nursing. They are also needed to dismantle the culture of silence and disrupt the privilege of Whiteness within these institutions that sustain discrimination and negatively impact students’ sense of belonging.
The power to create structures to address discrimination within the clinical environment relies on the cooperation of relevant decision makers within healthcare institutions. However, implementing anti-racist interventions within clinical placements will require a high degree of collaboration between Schools of Nursing and their clinical partnerships to ensure there is an alignment between their institutional goals and practices. When participants in this study did reach out to seek support with discrimination, they described attempting to do so by approaching members of their School of Nursing. This makes nursing educators well positioned to address incidents of discrimination faced by students and to assist students in accessing any formalized supports that may exist within the school they may need in relation to their experience (i.e., mental health support). Specific recommendations for how these institutions can collaborate in meaningful ways to implement anti-racist structures within clinical placements environments will be taken up below.

4.3.5 Implement Anti-Racist Interventions Within Clinical Settings and Nursing Education

A recent scoping review of the literature suggests that there is an overreliance on anti-racist interventions within healthcare environments that focus solely on individual behavior (Hassen et al., 2021). An overreliance on individual behavior ignores the role that organizational culture plays in influencing the behavior of individuals through processes of socialization (Griffith et al., 2007). Findings revealed that discrimination was perpetuated by power dynamics operating at numerous organizational levels including individual, interpersonal, and organizational. It was also revealed how educational and healthcare institutions have power in shaping the culture of an environment in which people belong through the values they espouse. Based on these
findings, I argue that anti-racist interventions that promote inclusion and disrupt discriminatory structures need to respect the complexity of individuals’ intersectional experiences of belonging by targeting numerous organizational levels within healthcare and nursing education. Hassen and colleagues (2021) provide some recommendations for anti-racist interventions at the individual, interpersonal, community, organizational and policy levels. At the individual level, they suggest investing in continuous anti-racism training for workers to assist them in addressing concepts related to racism and practice reflexivity. At the interpersonal level, they encourage the development of workshops that facilitate interactions between staff that seek to address harmful practices and instances of discrimination within the workplace. At the community level, they highlight the importance of developing meaningful collaborative partnerships with racialized communities to address discrimination within the clinical environment. At the organizational and policy levels, they recommend building formalized processes and structures within the organization to monitor policy and practice. Examples of these include the recruitment and retention of racialized individuals, the implementation of transparent accountability mechanisms to ensure racism is addressed, the collection of race-based data to identify disparities, and the incorporation of anti-racism into quality improvement initiatives. Although hospitals may already be engaging in some of these initiatives, some participants commented on how they were unaware of the proper channels to address discrimination, and how this acted as a barrier to disclosure of their experiences. To ensure anti-racist initiatives are effective, it is imperative that they are communicated and readily accessible to students. Given the dearth of literature on this
future research is required to investigate the impact of anti-racist initiatives on racialized nursing students sense of belonging.

4.3.6 Professional Development for Nursing Educators

In addition to the anti-racist interventions highlighted in the previous section, the results reveal an urgent need to provide professional development for nursing educators. Participants discussed how many of their nursing educators were inadequately prepared to address discrimination or actively engaged in harmful discourses that negatively influenced participants’ sense of belonging. Sedgwick and colleagues (2014) similarly found that clinical instructors who used discriminatory language negatively influenced students’ sense of belonging and that students expected their clinical instructors to intervene when they faced discriminatory behaviors from patients and staff. In the extant literature, nursing educators have repeatedly been criticized for their inability to address discrimination, or effectively teach topics related to racism, power, and privilege (Bell, 2020; Blanchet-Garneau et al, 2017; Holland, 2014; Van Bewer et al., 2021).

The onus to address discrimination cannot rely solely on those impacted by it. The findings of this study suggest that allyship during moments of discrimination is integral for some to experience a sense of belonging on the clinical unit. Thus, this thesis calls upon Schools of Nursing to invest in more personal and professional development for their educators, so they can be more adequately prepared to deliver anti-racist nursing education and address discrimination in the clinical environment. These professional development opportunities must center healthcare settings and academic institutions as places where discrimination may be reinforced, learned, and conversely, unlearned.
However, it is important to recognize that professional development alone would likely be an inadequate means of addressing the discriminatory behaviors and unpreparedness of nursing educators. Examples provided in the previous section, such as transparent accountability mechanisms and the recruitment of racialized individuals are also needed to disrupt the culture of Whiteness within nursing that socializes nursing educators into ways of thinking that perpetuate discriminatory behaviors.

4.3.7 Develop Transformative Nursing Curricula

The findings of this study also highlight gaps in nursing curricula that need to be addressed. Participants commented on how their nursing education inadequately prepared them to address the discriminatory experiences that negatively influenced their sense of belonging. Thus, we encourage nursing educators and academic institutions to review their syllabi and teaching practices to better incorporate learning outcomes that prepare learners to address discrimination in the clinical learning environment. Lane and Waldron (2021) recently developed a rubric that was designed to assist nursing educators in creating curricular content that is more relevant and impactful for diverse populations. Based on this rubric, numerous criteria need to be met for a syllabus to be considered transformative. Transformative course content would encourage learners to explore the impact of historical events on current health inequities and examine and critique how identities intersect within various structures of power to shape health. Transformative nursing education would also encourage learners to recognize the role that nursing professionals have as sociopolitical activists. Transformative nursing education will require leaders in curriculum development to create structures within nursing education
that enable learners to gather the skills required to address systemic racism within healthcare.

4.3.8 Improve the Representation of Racialized Individuals in the Nursing Profession

Through the last research question, we sought to explore the factors that influence nursing students’ sense of belonging on the clinical unit. One major implication for the findings of this study is the importance of ensuring that racialized individuals are well represented among nursing students, staff, and clinical instructors. Participants discussed how they found it difficult to feel a sense of belonging if they did not see individuals like themselves represented in the clinical space. It was also revealed by participants that racialized educators were frequently the only individuals who actively challenged discrimination or who provided students with adequate support with the discrimination they faced when they sought it. In Canada, healthcare and academic institutions do not routinely collect data that would offer insight into the representativeness of racialized individuals within nursing education or the nursing workforce (Jeffries et al., 2022). Without this data, it is easier for these institutions to dismiss the need to address any disparities that may exist in the representation of racialized individuals within nursing. Regardless of this lack of data, there is some evidence that supports the notion that the nursing workforce is predominantly white. Using data from Statistics Canada’s 2006 census, Premji and Etowa (2014) concluded that individuals who identified as a “visible minority” made up only 15% of the frontline nursing workforce in Canada. Additionally, their results suggest that racialized nurses represent far less of the nursing workforce within the setting of the study in this thesis (i.e., Canadian mid-sized cities). Of the cities they reported on, they found that the percentage of frontline nursing professionals who
identified as a “visible minority” within mid-size cities was drastically lower than what was reported in major Canadian cities such as Toronto or Vancouver (Premji & Etowa, 2014). Therefore, I argue that universities and healthcare institutions need to address the underrepresentation of racialized individuals within healthcare. However, discriminatory structures within universities and healthcare contexts can still pose barriers for the retention of racialized individuals within these institutions (Baker 2017; Henry et al., 2017; Mohamed & Beagan, 2019). Thus, it is also important for academic and healthcare institutions to invest in the appropriate tools and supports for racialized individuals as they navigate nursing workplaces and Schools of Nursing.

4.3.9 Deconstruct the Dominance of Individualistic Values in Canadian Society and Healthcare

The findings from this study also supports previous scholarship that has found that personal and professional values act as a factor influencing an individual’s sense of belonging. Participants discussed how they found it difficult to belong on the clinical unit if they perceived that they didn’t possess the same personal or professional values as the nurses they worked alongside. In their belongingness research, Sedgwick and colleagues (2014) similarly found that the Canadian racialized student nurses in their study felt they didn’t work alongside registered nurses who shared their personal and professional values. Additionally, through their research with nursing students, Levett-Jones and Lathlean (2008) provided a definition of nursing students’ sense of belonging that suggests that in order to belong, an individual must feel “that their professional and/or personal values are in harmony with those of the group”. In the broader context of the nursing profession, previous work has also highlighted how possessing differing values
from the dominant culture has contributed to feelings of alienation among internationally educated healthcare professionals (Safari et al., 2022).

This study expands upon the scholarship noted above by providing insight into how the dominance of individualistic values within Canadian nursing culture may contribute to clinical spaces that some nursing students may find difficult to belong. Some participants in this study perceived that many Canadian nursing professionals valued individualism, and remarked on how it was difficult for those who held a collectivist value orientation to experience a sense of belonging within clinical contexts. Participants responses suggest that feelings of alienation among individuals with collectivist values may be due to difficulties in finding a familiar sense of community within the individualistic culture of clinical spaces. Western countries (e.g., Canada and the United States) are often considered to have a predominantly individualistic culture, while Eastern countries are considered to possess a predominantly collectivist culture (Ladhari et al., 2015). One explanation for the prevalence of individualism within Canadian society is the dominance of neoliberal reform and ideology in Canada, the history of which has been explicated in previous scholarship (Gill, 2021). Broadly speaking, neoliberalists argue that an economic free market and privatization are the most effective means of organizing economic interests within society. A central tenet of this ideology is the erosion of social responsibility and community, as its proponents prioritize the responsibility and interests of the individual over the collective well-being of society (Lopez et al., 2021).

For other participants, a lack of belonging was informed by disagreements with their co-caring nurses’ individualistic values related to health. For example, one
participant commented on how their sense of belonging was negatively impacted when a
co-caring nurse denied providing care to a client based on the assumption that client
wasn’t fulfilling their personal responsibility to take adequate care of themselves at
home. Their sense of belonging was informed not only by the difference in values, but a
disagreement with the nurse’s approach to care. Within the context of Canadian nursing,
discourses of individualism have previously been reported in both nursing theory (Hilario
et al., 2017) and among practicing nurses (Horrill et al., 2021). One reason for the
prevalence of individualism among nursing professionals is the historical dominance of
the biomedical model in Canadian healthcare. A focus on biomedical perspectives within
Canadian nursing has socialized nurses to place greater value on the role of individual
behavior and personal responsibility over one’s health (Hilario et al. 2017). In the
previous example, this co-caring nurse was exhibiting an individualistic
conceptualization of health behaviors. Through an individualistic analytic lens, social and
political barriers to health are understood to be a given within society and personal choice
is primarily implicated as the main driver of health inequality (Blanchet Garneau et al.,
2017; Hilario et al., 2017; Kirkham & Browne, 2006). Within the ethos of individualism
is the false belief that with enough hard work, anyone can overcome structural barriers to
health and succeed (De Sousa & Varcoe, 2021).

A consequence of the dominance of individualism in nursing is an anti-social
justice orientation within the profession. Social justice is advanced when we remove the
social and political barriers that influence health outcomes (Abu, 2020; United Nations,
2020). As a result of individualistic health values, the structural barriers that influence
health remain largely unchallenged, and social justice as a core tenet to the nursing
profession remains unrealized. Instead, individualistic beliefs that center personal responsibility frequently stigmatize individuals by implicating them as being at fault for their health condition. Ultimately, for social justice initiatives to be furthered in the nursing profession, the broader structural forces that intersect to shape health outcomes need to be recognized and opposed (Blanchet Garneau et al., 2017). Thus, to center social justice as a core tenet to the nursing profession, I argue that there is a need to develop diverse strategies to deconstruct the hegemonic individualistic worldviews that contribute to an anti-social justice orientation within the profession.

To begin to deconstruct the dominance of individualism in Canadian nursing, I return to my previous call to action to improve the representation of individuals with diverse identities at all levels in healthcare and nursing. Homogeneity within the nursing profession perpetuates dominant approaches to care that exclude the values and ideals of underrepresented groups (Jeffries et al., 2018). Additionally, Gosine (2021) has previously argued that a collectivist orientation is common among many minoritized communities from predominantly poor or working-class backgrounds and is rooted in the social bonds formed through histories of marginalization based on intersections of race and class. Thus, increasing diversity within nursing can aid in disrupting the Eurocentric and classist values that shape the clinical environments in which students seek belonging and inform how nurses conceptualize health. However, it is important to recognize the potential of exposing more minoritized individuals to harm if they are entering institutions where little has been done to disrupt the discriminatory policies and practices that contribute to their experiences. Organizational and policy level initiatives should be
prioritized by institutions to address discriminatory practices and policies, prior to (or in conjunction with) increasing diversity within the profession.

Secondly, nursing professionals primarily internalize the values of the nursing profession through the process of socialization (Bell, 2020). Thus, to ensure that social justice is instilled as a core value in the profession, it is integral to disrupt discourses in nursing education and practice that reify the dominance of individualism. In 2011, Van Herk and colleagues attempted to address the dominance of Eurocentric values in nursing by calling for the incorporation of an intersectionality paradigm into the profession. Their goal in making this call to action was to “debunk the hegemony of the “white, middle-class perspective that governs nursing research, practice, and education” (Van Herk et al., 2011). Despite the fact that Van Herk’s call to action took place twelve years ago, a recent review on intersectionality and nursing leadership found that this call to action had been met with a poor response (Aspinall et al., 2022). It was concluded that there has been “little challenge to the continuing dominance of a white, middle-class leadership perspective that limits who is recognized as a possible nursing leader” (Aspinall et al., 2022). By examining the interlocking structures of oppression and power dynamics that shape health, the integration of an intersectionality paradigm into nursing offers a means for nursing leaders to begin to deconstruct the dominant individualistic discourses rooted in the Eurocentric foundations of the nursing profession. Existing frameworks such as Came and Griffith’s (2018) anti-racism praxis, and Blanchet Garneau and colleagues’ (2017) critical anti-discriminatory pedagogy offer direction for nursing leaders looking to integrate tenets of intersectionality into nursing education and practice.
4.4 Strengths and Limitations

A key strength of this research was the intersectional theoretical lens that was utilized throughout this study. This lens allowed the researcher to develop a nuanced understanding of how nursing students’ identities intersected with structures of power to shape their experiences of belonging. As argued in chapter two of this thesis, researchers who utilize an intersectional framework may produce a more comprehensive understanding of the interrelated factors that perpetuate inequities. Thus, future research exploring a sense of belonging should strongly considering applying an intersectional theoretical lens to their work. Secondly, a strength of this research was the use of maximum variation sampling. As the purpose of this research was to explore the experiences of racially and ethnically minoritized nursing students, the researcher was successful in recruiting a diverse sample of unique intersectional identities that provided insight into different social positions that may inform a sense of belonging.

One limitation of the study was that the sample size was limited to eight participants. Although this was an acceptable amount to answer the research questions for this qualitative design as determined by the richness of the data, a larger sample size may have provided additional insight. Secondly, participants were recruited from two universities in Ontario-based mid-sized cities. Thus, the experiences of belonging shared by participants may only be reflective of racially and ethnically minoritized nursing students’ experiences of belonging within these specific contexts. Future researchers should attempt to explore nursing student’s experiences of belonging within different academic contexts (i.e., classrooms, simulated learning settings) or geographic locations to explore these experiences within different educational settings or regions of Canada. Furthermore, while this study contributes to a gap in the literature on racially and/or
ethnically minoritized nursing students’ experiences of belonging during their clinical placements, it is important to note that the results do not represent the experiences of all nursing students with racially or ethnically minoritized identities. Finally, as this study focused on nursing students with racially and ethnically minoritized nursing students, the findings and discussion do not capture the full intersectional complexity of participants’ experiences. Participants were encouraged to share any aspects of their identity that they were comfortable sharing with the researcher. However, the researcher only explicitly asked participants to identify their race, ethnicity, gender, and nationality which may have limited his ability to capture participants’ intersectional experiences of belonging more thoroughly. Future researchers would benefit from exploring how other factors such as class and 1st generation status intersect with other identifiers to inform participants’ experiences.

4.5 Conclusion

Informed by intersectional theoretical perspectives, this interpretive descriptive study provides an exploration of the experiences of belonging among racially and ethnically minoritized nursing students situated in two mid-sized cities in Ontario, Canada. The findings support previous work that identifies belonging as integral to students’ learning process during clinical placements. However, the findings also shed light on the systemic barriers to belonging that racially and ethnically minoritized nursing students may face as they navigate discriminatory clinical environments and power dynamics that silence their experiences. These findings speak to the importance of dismantling discriminatory structures within nursing education and practice and of investing in strategies to improve student belonging. Ultimately, improving racially and
ethnically minoritized students’ sense of belonging during their clinical placements has positive implications for student learning, patient safety, and for retaining a diverse nursing workforce. Strategies to address barriers to student belonging need to be comprehensive in their approach by targeting the personal, interpersonal, community, organizational and policy level factors that contribute to their prevalence.
4.6 References


## Appendix A: Calls to Action

### Overview

The study "The Experiences of Clinical Placement Belonging Among Nursing Students with Racially and Ethnically Minoritized Identities: An Interpretive Descriptive Study" provides an exploration of the experiences of clinical placement belonging among racially and ethnically minoritized nursing students. The findings identified belonging as integral to students' learning process, retention and patient safety. However, the findings also shed light on the systemic barriers to belonging that racially and ethnically minoritized nursing students may face as they navigate discriminatory clinical environments and power dynamics that silence their experiences. These findings speak to the importance of a long-term commitment to dismantling discriminatory structures within nursing education and practice and of investing in strategies to improve student belonging. This document provides a summary of the multi-level recommendations for committed action from relevant decision makers to foster safe learning environments that embrace equity, diversity and inclusion.

<table>
<thead>
<tr>
<th>Intervention Level</th>
<th>Actionable Initiative</th>
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<tbody>
<tr>
<td><strong>Individual &amp; Interpersonal</strong></td>
<td>• Provide anti-racism training to all staff on an ongoing basis to allow individuals to critically reflect on their beliefs and attitudes</td>
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<td></td>
<td>• Develop workshops that facilitate interactions between staff and address harmful practices within the clinical environment</td>
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<tr>
<td><strong>Community</strong></td>
<td>• Engage in authentic partnerships with racialized communities to collaboratively address discrimination within clinical settings</td>
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<tr>
<td><strong>Organizational</strong></td>
<td>• Provide formalized opportunities for students to give feedback on their experiences of belonging in the clinical environment to address the invisibility of these experiences and improve the relevance of initiatives designed to promote student belonging.</td>
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<td>• Collect race-based data to identify disparities in the representation of diverse individuals at all levels of academia and healthcare (i.e., students, educators, nurses, leadership).</td>
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<td></td>
<td>• Develop recruitment strategies that aim to address the underrepresentation of racialized persons in academia and healthcare.</td>
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<td></td>
<td>• Create transparent accountability mechanisms to address discrimination in the clinical setting.</td>
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<td></td>
<td>• Integrate culturally relevant supports for racialized staff and students to assist them in navigating challenges specific to their unique identities.</td>
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<tr>
<td></td>
<td>• Ensure that supports, learning opportunities, and services are communicated at regular time intervals to improve awareness and accessibility of these services.</td>
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<tr>
<td><strong>Policy</strong></td>
<td>• Ensure institutional policies explicitly demonstrate a commitment to values of equity, diversity and inclusion.</td>
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<td></td>
<td>• Incorporate anti-racism into quality improvement initiatives by developing targets and actions directed at achieving the actions above</td>
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<td></td>
<td>• Ensure that relevant committees or persons engaged the above initiatives are afforded with adequate time to conduct this work.</td>
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Appendix B: Interview Guide

Demographic Questions

1) In this study we are interested in exploring how your personal social identity may influence your experience of belonging. Keeping that in mind, could you tell me a little bit about who you are as a person and how you identify yourself?

Possible Prompts:
   a) Race: What would you identify as your racial identity?
   b) Ethnicity: What would you identify as your ethnic identity?
   c) Gender: What gender do you identify as?
   d) Nationality: What is your nationality and/or ancestry?
   e) Are there any other ways that you identify yourself that you would like me to know about?
   f) How do these identities that you shared intersect to define you?

Interview Questions

1) Could you tell me about your experience of belonging within the clinical environment?

   Possible Prompts:
   a) How have clinical instructors influenced your experience of belonging?
   b) How have nurse mentors influenced your experience of belonging?
   c) How have your peers influenced your experience of belonging?
   d) How have patients influenced your experience of belonging?
   e) What does belonging in the clinical environment mean to you?
   f) What does having a sense of belonging look like to you?

2) Can you tell me about a time you didn’t belong within the clinical environment?

   Possible Prompts:
   a) What about this experience made you feel as if you didn’t belong?
   b) Do you think your race might have had anything to do with your experience of belonging? Please explain?
   c) Do you think your ethnicity might have had anything to do with your experience of belonging? Please explain?
   d) Do you think your gender might have had anything to do with your experience of belonging? Please explain?
   e) Do you think the culture of nursing might have had anything to do with your experience of belonging? Please explain?
   f) What, if anything, about the intersection of the categories you belong to or identify with makes it easy or hard to belong during your clinical placements?
   g) Do you think your intersecting categories make it harder or easier to belong compared to other people? Why?
   h) How might structures of power (e.g., racism) impact your experience of belonging?
i) How might experiences of discrimination or oppression based on intersecting categories impact beliefs about your capability to belong either for yourself or for others?

j) From your perspective, what knowledge or action is required to improve your experience of belonging?

k) How much of a priority is it for you to belong in the clinical environment?

3) Could you describe any additional factors that influence your sense of belonging within the clinical environment?

4) If you could speak directly to the dean of the university or director of the nursing program, what would you want them to know about your experience of belonging?

5) Can you describe how your experience of belonging has impacted your mental health and well-being?

Possible Prompts:
   a) What aspects of your experience of belonging have impacted your mental health and well-being?
   b) Can you tell me about any resources or supports (e.g. organizations, services) that you have utilized in relation to your experience of belonging?
   c) What part of these resources or supports were helpful?
   d) What part of these resources or supports were unhelpful?
   e) In what ways might your intersecting categories influence whether you accessed support?
   f) What made it difficult to access this support?
   g) What made it easier to access this support?
   h) Would you use this resource or support again?
   i) If you haven’t accessed any resources or supports in relation to your experience of belonging, could you tell me why that might be?

6) Is there anything else you want to talk about in relation to your experience of belonging that I did not ask?

Feedback Questions

a. Did you feel that the interview was an appropriate length?

b. Did you find the interview questions were easy enough to understand?

d. Do any of the interview questions need to be removed, or altered in any way?

e. Are there any additional questions that you think I should have asked?
g. Are there any suggestions you have to make the interview process and questions more effective?
Appendix C: Letter of Information and Consent

Letter of Information and Consent
Version Date: 15/05/2022

Project Title: The Experiences of Clinical Placement Belonging Among Nursing Students with Racially and Ethnically Minoritized Identities: An Interpretive Descriptive Study

Principal Investigator
Dr. Susana Caxaj, PhD
Associate Professor, Arthur Labatt Family School of Nursing at Western University

Additional Research Members
Connor Gould, RN, MScN Student
Arthur Labatt Family School of Nursing at Western University

1. What should I know about this research?
The researcher will take time to review this document with you before you choose whether you wish to participate. Your involvement in this research is completely voluntary. If you choose not to participate, it will not be held against you in any way. If you don’t understand any part of the research, please ask a question. You can ask as many questions as you like before you decide whether or not you wish to participate.

2. Invitation to Participate
You are being invited to participate in this research study regarding your experience of belonging during your clinical placement rotations. Specifically, you are invited to participate because your experience is valuable in providing insights into the experiences of students with racially and ethnically minoritized identities within Canadian nursing education. This study will provide data to be included in the master’s thesis project for Connor Gould, a current MScN student within the Arthur Labatt Family School of Nursing at the University of Western Ontario.

We recognize that individuals identify themselves in diverse ways and that racial and ethnic identity might have different meanings for different peoples. For the purpose of this study, when we refer to racially and ethnically minoritized identities, we refer to individuals that are subject to marginalization and oppression based on their self-identified cultural identity (such as language, religion, or traditions) and/or personal characteristics (such as skin, hair, or eye color)."

3. Why is this study being done?
The purpose of this study is to recognize and acknowledge the experiences of clinical
placement belonging among nursing students with racially and ethnically minoritized identities. Although students with racially and ethnically minoritized identities may face unique barriers to belonging such as racial and ethnic discrimination, limited research has been conducted to explore their experiences of belonging during clinical placements. We are interested in learning from your experiences of belonging during clinical placements to deepen our understanding of student belonging as well as inform anti-racist and anti-oppressive transformative change within Canadian schools of nursing.

4. How long will you be in this study?
If you consent to participate, it is expected that you will be asked to participate in at least one interview during the study. Throughout the course of the study the researcher may have follow up questions and request your participation in a second interview. The initial interview is expected to last approximately 60-90 minutes, and any potential second interview will take approximately 30 minutes. It is expected you will be in the study for a period of approximately ten months. Second interviews will be conducted anywhere from 1 to 9 months after the first interview.

5. Inclusion Criteria
To be eligible to participate in the study, you must meet the following inclusion criteria:
You self-identify as a nursing student with a racially and ethnically minoritized identity.
You are able to read and speak English in order to be able to converse with the researcher. You are currently enrolled in a Canadian baccalaureate nursing program.
You have fully completed at least one clinical rotation through your nursing program.

6. What are the study procedures? Interviews will take place through video conference using the online platform Zoom. Please note, the researcher wishes to record the audio and video of each interview for the purpose of transcription and data analysis. The audio and video of each interview will be recorded with your consent, as data analysis will require the researcher to read transcribed interviews alongside the video recordings. Audio and video recording of the interview will be mandatory for your participation in the study to ensure accuracy during data analysis We encourage you to join the video conference in a place where your privacy can be maintained and where you have access to the video conference software Zoom.

   If you agree to schedule an interview time with the researcher, a videoconference meeting can be scheduled during a time and day that is convenient to you. At the beginning of this videoconference meeting, the researcher will answer any questions you may have and review The Letter of Information and Consent with you so that you can make an informed decision about your participation in the research. After reviewing the Letter of Information and Consent with the researcher, if you choose to participate you will be asked during the videoconferencing meeting to sign an electronic consent form. Due to Covid-19, signed consent documents will be provided to you via email. During the initial interview, the researcher will ask you approximately 20 questions related to your
experience of belonging during your clinical placements.

7. What are the risks and harms of participating in this study? There are no known or anticipated risks or discomforts associated with participating in this study. However, during interviews you may be asked to discuss sensitive topics that might be uncomfortable and emotional. You can decline to answer any questions you do not wish to answer. You may also withdraw your participation at any time during the interview process. Following your first interview, the researcher will provide you with a list of free mental health resources during the videoconference that we encourage you to access if needed.

8. What are the benefits of participating in this study? You may not directly benefit from participating in this study. However, the information you provide may inform current educational practices. Your lived experience of belonging as a nursing student with a racially or ethnically minoritized identity has the potential to inform actionable initiatives within Canadian Schools of Nursing that aim to address systemic barriers to student belonging and create a more equitable student experience.

9. Can participants choose to leave the study? If you decide to withdraw from the study, you have the right to request withdrawal of information collected about you. It is important to note that a record of your participation must remain with the study, and as such, the researchers may not be able to destroy your signed letter of information and consent, or your name on the master list. However, any data may be withdrawn upon your request. If you wish to have your information removed, please contact Connor at [email address] and your information will be destroyed from our records. Once the study has been published, we will not be able to withdraw your information.

10. How will participants’ information be kept confidential?
10.1 Delegated institutional representatives of Western University and its Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research in accordance with regulatory requirements.

10.2 The researcher will keep all personal information about you in a secure and confidential location for 7 years following completion of the study in accordance with Western University’s Collective Agreement. At the end of your interview, you will be asked during the videoconference to provide a pseudonym of your name to ensure your anonymity. A list linking your pseudonym with your name, and any other identifying information will be kept by the researcher in a secure place, separate from your study file.

10.3 All files will be collected, coded, analyzed and kept on a private Western server protected by a password. If the results of the study are published, your name will not be used, and all attempts will be made to keep your identity confidential. Participants will be provided with a copy of the final report upon request.
10.4 The following identifiable information will be collected: your full name, e-mail address, phone number, an audio and video recording of the interview, and any demographic information that you are willing to share (i.e., race, ethnicity, gender etc...). Your full name will be collected so that we can obtain informed consent. Your e-mail address and phone number may be collected so that we can communicate a date, and time for your interview. Your demographic information will be collected for the purpose of data analysis. Please note that because we are collecting personal identifiers, there is always the risk of a privacy breach.

10.5 We may use direct quotes from your interview in our final report. However, the quotes will use the pseudonym you provide instead of your name to protect your identity. Other potentially identifiable information such as your academic institution, or city will be replaced with a pseudonym to protect your identity. The demographic information you provide (i.e., race, ethnicity, gender etc...) may be used in academic publications and public reports to highlight how different social positions may influence experiences of belonging and may allow someone to link the data and identify you. No demographic information that identifies you specifically will be published. If you do not consent to the use of direct quotes or the dissemination of your demographic information, you may still participate in the study.

10.6 The teleconferencing software Zoom will be used to conduct online interviews with you. If you wish to view Zoom’s privacy policy, it can be viewed at this link (https://explore.zoom.us/en/privacy/). Any of your personal data collected by Zoom is stored in data centers in Canada and the United States. Like online shopping, teleconferencing/videoconferencing technology has some privacy and security risks. It is possible that information shared through this platform could be intercepted by unauthorized people (hacked) or otherwise shared by accident. This risk can’t be completely eliminated. We want to make you aware of this.

10.7 The online survey software tool Qualtrics will be used to obtain your informed consent electronically. If you wish to viewQualtrics’ privacy policy, it can be viewed at this link (https://www.qualtrics.com/privacy-statement/). Any of your personal data collected by Qualtrics is stored in data centers in Ireland. It is possible that information shared through this platform could be intercepted by unauthorized people (hacked) or otherwise shared by accident. This risk can’t be completely eliminated. We want to make you aware of this.

11. Are participants compensated to be in this study?
You will not be compensated for your participation in this research.

12. What are the rights of participants? Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you
choose not to participate or to leave the study at any time it will have no effect on your academic standing. We will inform you immediately of any new information that may affect your decision to stay in the study. You do not waive any legal right by signing this consent form.

13. **Whom do participants contact for questions?** If you have questions about this research study, please contact Connor Gould at [e-mail address].

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics [phone number], [alternate phone number], email: [e-mail address]. This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.

**This letter is yours to keep for future reference.**

Q1 This study has been explained to me and any questions I had have been answered. I know that I may leave the study at any time. I agree to take part in this study. I will be emailed a copy of this document.

- Yes (1)
- No (2)

Q2 I consent to the use of unidentified quotes obtained during the study in the dissemination of results

- Yes (1)
- No (2)
Q3 I agree to have indirectly identifiable information related to my self-identified identity [such as my race, ethnicity, and gender etc.] used in the dissemination of this research.

☐ Yes (1)
☐ No (2)

Q4 I would like a copy of the final report sent to me via email

☐ Yes (1)
☐ No (2)

Q12 Type First Name of Participant

____________________________________________________________

Q13 Type Last Name of Participant

____________________________________________________________

Q14 Signature of Participant

____________________________________________________________

Q15 Today’s Date (mm/dd/yyyy)

____________________________________________________________

Q16 For Research Team Use Only (if you are a participant, please proceed using the next arrow below to submit)

My signature means that I have explained the study to the participant named above. I
have answered all questions.

Type name of person obtaining Informed Consent (to be completed by researcher on submission)

________________________________________________________________

Q17 Signature of person obtaining Informed Consent (to be completed by research team on submission)

________________________________________________________________

Q18 Date person obtaining informed consent signs (mm/dd/yyyy)

________________________________________________________________
Appendix D: Email Script for Recruitment

Email Script for Recruitment
(to be used when the contact information is publicly available or appropriate permissions to use email have been received)

Subject Line: MASS EMAIL RECRUITMENT

Hello,

We are looking for volunteers to participate in a study that explores how nursing students with racially or ethnically minoritized identities experience a sense of belonging during their clinical placements. We are looking for nursing students who meet the following criteria:

1) You self-identify as having a racially or ethnically minoritized identity (see description below)
2) You are fluent in English
3) You are currently enrolled in a Canadian baccalaureate nursing program
4) You have fully completed at least one clinical placement rotation through your program.

- We recognize that individuals identify themselves in diverse ways and that racial and ethnic identity might have different meanings for different peoples. For the purpose of this study, when we refer to racially and ethnically minoritized identities, we refer to individuals that are subject to marginalization and oppression based on their self-identified cultural identity (such as language, religion, or traditions) and/or personal characteristics (such as skin, hair, or eye color).

If you meet the criteria and are interested in participating, you would be asked to:

- Participate in an interview with the researcher lasting approximately 60 to 90 minutes where you will be asked to describe your experience of belonging during your clinical placements. Throughout the course of the study the researcher may have follow up questions and request your participation in a second interview lasting approximately 30 minutes.

If you would like more information on this study or would like to receive a letter of information about this study, please contact the researcher Connor Gould at [e-mail address]. As a quick reminder about this study, we will be sending this e-mail again two
weeks following this e-mail. We will also send a final reminder about this study one month following this e-mail

Thank you,

Connor Gould, RN, MScN Student, Arthur Labatt Family School of Nursing

Dr. Susana Caxaj (Principal Investigator)
Associate Professor, Arthur Labatt Family School of Nursing
4.7 Appendix F: Ethics Approval

Western Research

Date: 18 May 2022

To Dr Claudia Susana Cerej
Project ID: 120877

Study Title: The Experiences of Classical Placement Among Nursing Students with Racially and Ethnically-Minoritized Identities: An Interpretive Descriptive Study

Short Title: Classical Placement Among Nursing Students with Racially and Ethnically-Minoritized Identities

Application Type: NMSREB Initial Application

Review Type: Deligated

Full Board Reporting Date: 09 Jan 2022

Date Approval Issued: 18 May 2022 16:33

REB Approval Expiry Date: 18 May 2023

Dear Dr Claudia Susana Cerej

The Western University Non-Medical Research Ethics Board (NMSREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMSREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMSREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.

Documents Approved:

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<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
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<td>06 May 2022</td>
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<td>Sense of Belonging Second Interview Guide</td>
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<td>One Month Reminder E-Mail</td>
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<td>Written Consent/Assent</td>
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Documents Acknowledged:

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<td>Participant Resources</td>
<td>Other Materials</td>
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No deviations from, or changes to the protocol should be initiated without prior written approval from the NMSREB, except when necessary to eliminate immediate hazards to participants or when the changes involve only administrative or logistical aspects of the trial.

The Western University NMSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMSREB who are named as investigators in research studies do not participate in discussions related to, nor vote on, such studies when they are presented to the REB. The NMSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000041.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Ms. Zoe Levi, Research Ethics Officer on behalf of Dr. Randol Graham, NMSREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).
Curriculum Vitae

Name: Connor Gould

Post-secondary Education and Degrees:

University of Western Ontario
London, Ontario, Canada
2012-2016 BScN

The University of Western Ontario
London, Ontario, Canada
2019-Present MScN

Honours and Awards:

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2020

Related Work Experience:

Teaching Assistant
The University of Western Ontario
2020-2021

Professor
Fanshawe College
2022

Lecturer
Arthur Labatt Family School of Nursing
2021-Now