Decentering Whiteness in Nursing Education: The Pitfalls, Tensions, and Opportunities

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Abstract

**Statement of Research Problem:** The Truth and Reconciliation 94 Calls to Action (TRC) (2015) calls for the implementation of accessible and appropriate Indigenous health education. Schools of Nursing are increasingly implementing various approaches to teach Indigenous health. Limited research exists for Canadian nursing students' experiences of learning Indigenous health. This study explored undergraduate nursing students’ experiences of learning Indigenous health from four Schools of Nursing across Canada. Particular attention is paid to the factors that shaped student and faculty experiences of learning and teaching Indigenous health, respectively, the facilitators and challenges, and what constitutes a safe and effective learning environment.

**Methods:** Using a qualitative methodology informed by critical ethnography nine semi-structured interviews were conducted with six undergraduate nursing students and three faculty members. Postcolonial theory was used to inform the work and a thematic analysis was utilized to elicit themes.

**Results:** Findings resulted in five overarching themes: (1) *encountering racism in education and practice*, (2) *need for faculty development*, (3) *decentering whiteness in the classroom*, (4) *creating cultural safety in the classroom*, and (5) *from classroom to practice*.

**Conclusions:** Findings suggest that for transformative work to take place, the education system needs to work towards better representation of Indigenous faculty and students. Healthcare and education settings need to collaborate to develop anti-racist, anti-oppression, and decolonizing policies and procedures to support the translation of classroom learning into clinical practice. All work should be in partnership with local Indigenous communities.

**Keywords:** Indigenous health, nursing, nursing student, critical ethnography, education, anti-racism, undergraduate nursing, cultural safety, reconciliation, decolonization, indigenization
Summary for Lay Audience

This study aimed to critically explore undergraduate nursing students’ experiences of learning Indigenous health education in Canadian schools of nursing. The Truth and Reconciliation Commission called upon nursing educators to include Indigenous health education within curriculum to address issues of health care racism experienced by Indigenous peoples and communities when they sought care in clinical settings such as hospitals. This study aimed to gain understanding of the culture with which students are immersed in and learn in throughout their undergraduate studies. It is hoped that better understanding of the culture of learning and its facilitators and challenges for students will shed light on how (neo)colonialism manifests and can be challenged to promote culturally safe learning and in turn, safer care for Indigenous peoples.

We were able to interview six nursing students and three nursing faculty to understand their learning and teaching experiences respectively. The five overarching themes tells us about the facilitators, challenges, tensions, pitfalls, and potential opportunities to improve upon Indigenous health education, policy, practice, and research.
Co-Authorship Statement

Ivy Tran conducted this research work during her Master of Science in Nursing (MScN) program under the supervision of Dr. Victoria Smye (principal investigator) and Dr. Fiona Webster (committee member) who will be co-authors of this publication resulting from the manuscript.
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Thank you to my family and loved ones who have stood beside me with your unwavering support during the challenges I have experienced during the course of this graduate work and for being a source of encouragement when I needed it most.

I would further like to thank the Schools of Nursing who supported this research study to take place at the schools and for championing and disseminating this important work multiple times despite the challenges of recruitment during the COVID-19 pandemic from 2020-2022.

Lastly, I would like to acknowledge and thank all the study informants – students and faculty who took the time to respond to this study and continued to be a part of the follow up. Without your contribution, this work would have not been possible. I acknowledge your unique stories, your bravery, vulnerability, and strengths in your own learning and un-learning journeys, as well as your continued strife to overcome colonial challenges and ‘walk the talk’ in Indigenous health education reform.

I am thankful to you all and hope we can continue these important conversations beyond this study.
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Chapter One: Introduction

Decentering Whiteness in Nursing Education: The Pitfalls, Tensions, and Opportunities

Indigenous populations worldwide experience stark health and social disparities by any measure in comparison to non-Indigenous populations (Richmond & Cook, 2016; Kinchin, Mccalman, Bainbridge, Tsey, & Lui, 2017; Crocetti et al., 2022). In countries that share similar colonial histories (the United States, Australia, Canada, and New Zealand), colonialism continues to shape the social determinants of health for Indigenous populations (Mills, Creedy, & West, 2018). Canada, a westernized country, “has long prided itself on being a bastion of democracy, peace, and kindness throughout the world” (TRC, 2015, v). As a country, our “commitment to primary health care and principles of social justice” have been duly noted (Browne, Varcoe, Lavoie, Smye, Wong, Krause, Tu, & Godwin, 2016, p. 544; Greenwood, de Leeuw, & Lindsay, 2018). However, “deep inequities persist in wellness indicators and access to health care services for Indigenous populations in Canada” (Greenwood, de Leeuw, & Lindsay, 2018, p.1646). Richmond & Cook (2016) posit that there is a significant lack of political will at the federal level in creating national public policy for Indigenous health.

On this front, Canada remains a first-world country faced with fourth-world living conditions for many Indigenous peoples who live here (Fukurai, 2018). Fourth-world is a term used to describe an extension of the third world. The term gained popularity to highlight internationally unrecognized nations within colonized states (Seton, 1999). These nations represent “a third of the world’s population whose descendants maintain a distinct political culture that predates and continues to resist the encroachment of the (colonizer) state” (Seton, 1999). I use the term ‘fourth-world’ in this context to draw attention to the inequities that persist
in a country with so much wealth. However, it can be taken up in various ways, and it is not my intention to set the stage for ‘othering’ nation states.

In these nations, several poignant conditions have been well documented and minimally addressed. This includes the lack of adequate basic household sanitary infrastructure, affordable housing, overcrowding apparent in reserve dwellings, and drinking water advisories in one-fifth of First Nation communities (Richmond & Cook, 2016; Varcoe et al., 2016). Overcrowded dwellings are known to be synonymous to homelessness, as community members may be left unhoused if they are not taken in (Richmond & Cook, 2016).

Within the Canadian healthcare system, the case of Brian Sinclair remains significant as to how health care provisions continue to harm Indigenous individuals seeking care (Ray, Wylie, & Corrado, 2022). Brian Sinclair was an Indigenous man who was “ignored to death” (Camus, 2022, p. 1) with a treatable infection in a Winnipeg hospital emergency room in December 2008. Joyce Echaquan’s preventable death in 2020 at a Quebec hospital also demonstrates the systemic racism experienced by Indigenous peoples seeking health care services (Browne, Lavoie, McCallum, & Canoe, 2022). Echaquan had filmed nurses and orderly aides mocking and citing racist remarks against her. In McCallum and Perry’s book (2018) ‘Structures of Indifference’, racism is said to have a set time, place, and context. The authors assert,

In the medical field, racist practices are embedded in a long and nationwide history of racial segregation in hospitals, and notions of who is and who is not deserving of medical care and what that care might look like are intimately tied to political, economic, religious, technological, and cultural influences. (p. 16)

Brian Sinclair and Joyce Echaquan’s fate, along with many other Indigenous peoples, continues to be in the hands of a racist health care system. Sinclair was simply denied care
because health care professionals, along with other hospital staff held preconceived notions that Mr. Sinclair was “sleeping it off”, “drug seeking”, and/or “homeless” (Ray, Wylie, & Corrado, 2022). These prejudices and discourses are exactly why structures of violence need to be exposed and resolutions brought forward in current health care landscapes for individuals marginalized by inequity. It is the responsibility of nurses and other health care providers to provide ethical care that is non-discriminatory and culturally safe. I will expand on cultural safety in the next section.

**Defining Cultural Safety**

A central premise of cultural safety is that the recipients of care determine what is culturally safe or unsafe (Papps & Ramsden, 1996; Smye, Josewski & Kendall, 2010). Health professionals, especially nurses, must work collaboratively with Indigenous peoples to rectify current problems related to care provision and to support cultural safety (Ramsden, 1993). Cultural safety is a critical lens and a powerful nursing concept defined as,

> “the effective nursing of a person/family from another culture by a nurse who has undertaken a process of their own identity and recognizes the impact of the nurse’s culture on their own nursing practice [to mitigate cultural risk]” (Roy-Michaeli, 2011, 11; Wepa, 2005).

Unsafe cultural practice/cultural risk is any practice, which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual (Roy-Michaeli, 2011).

Ramsden (1994), a Māori nurse in Aotearoa (New Zealand) who introduced the concept of cultural safety, asserts that nurses need to bear in mind that we are also “bearers of culture” and to examine our own current realities, attitudes, and behaviors and the impact these can have on others. This includes the power imbalances within a healthcare interaction. As nurses, we
hold inherent power in the professional title and in the health knowledge we have. Cultural safety requires the utmost respect for Indigenous knowledge and practices that facilitate wellness. The inclusion of Indigenous ways to health as legitimate interventions cannot be undermined as an option when providing healthcare services (ANAC et al., 2009; Smye, Josewski, & Kendall, 2010).

Cultural safety requires health professionals to enact cultural humility and critical reflection into our own biases, assumptions, privilege, and power. Doing so fosters open-mindedness to deepen our learning of individuals who are different from us, while recognizing how one’s own biases and own positionality can impact the care they receive (Schill & Caxaj, 2019).

In Canada, prime examples of cultural safety being taken up include the framework by Aboriginal Nurses Association of Canada (ANAC) et al. (2009) that provided a guideline for nursing leaders in education and the San’yas Indigenous Cultural Safety Training (Provincial Health Services Authority in BC), that provides trainees with the foundational knowledge of the colonial histories through interactive-reflective weekly modules.

The transportability of the cultural safety framework is also evidenced by its applicability in research (Browne et al., 2018; Kirkham et al., 2002; Nelson & Wilson, 2018; Varcoe & Dick, 2008; Smye et al., 2010), critical analyses of health policies (Smith, Varcoe, & Edwards, 2005; Smye & Browne, 2002), and in practice (Browne et al., 2009; Maar & Shawande, 2010; Schill & Caxaj, 2019). Cultural safety in these examples underline the concept’s value in interpreting power imbalances in healthcare, as it “emphasizes the need for health care institutions to critically reflect on the colonial precedents of the care that they provide that contribute to these power imbalances” (Nelson & Wilson, 2018, p.25). Cultural safety as a process can necessitate
interpersonal and structural interventions needed to create an equitable and culturally safe healthcare workforce.

**Teaching Indigenous Health**

Cultural safety, as a concept and process, will certainly see further growth within nursing education. However, current approaches to learning cultural safety in relation to Indigenous health varies across educational institutions. It is often difficult and not a one-size-fits-all formula within schools of nursing. We cannot be certain how various approaches to teaching Indigenous health content is taken up by nursing students, and in turn, how this changes attitudes and behavior in the context providing care in clinical settings. This highlights the need to explore nursing students’ experiences of learning Indigenous health within Canadian schools of nursing.

**Significance of Indigenous Health to Nursing**

Indigenous health concerns are of significance to the nursing profession as nurses can either be an accomplice with Indigenous peoples toward reconciliation or be complicit in perpetuating oppression, structural and interpersonal violence against Indigenous peoples (Hole et al., 2015).

An *accomplice* is defined as “a person who helps another commit a crime” and has become a more widely used term in social justice literature (Google Dictionary; Admin 2016). It is different from the commonly used term “ally”, which means, “a member of an oppressor group who works to end a form of oppression which gives him or her privilege” (Atkinson, 2010, p.14). Although it is still widely used by Indigenous and non-Indigenous persons in this field of work, an ally, broadly used, is not a term in alignment with social justice. “Accomplice”, on the other hand, is a term about war alliances who share the burden of combatting in war together (Rich, 2019). Allyship has seemingly been “rendered ineffective and meaningless” due to
activists’ exploitation of the term as an identity status rather than an enactment of actions in solidarity with Indigenous peoples (Admin, 2016). Being an accomplice is about

*sharing the burden of the fight [and war][...] taking personal risks, giving up personal power and even personal safety in order to be a part of liberating someone else. An accomplice [does not] just stand with or even just speak out, they do, they act, they de-center themselves actively. Accomplices see the work of solidarity as a verb, not a noun.*” (Rich, 2019).

Nurses, including nurse educators, and leaders at all levels can no longer play the “perfect stranger” whereby Indigenous issues are perceived to be only “between the government and Indigenous Peoples themselves” and that others outside of those spheres are not implicated (Dion, 2013). Tuck & Yang (2012) assert that this is a move toward innocence on the part of settlers who feel guilt and uncomfortable emotions in learning the histories and current issues within Indigenous health. However, this is not the case for many nurse leaders who have started reconciliation efforts within schools of nursing. Understanding how reconciliation in the form of Indigenous health education is implemented, what it looks like, and how it is affecting nursing students would be invaluable knowledge to inform reconciliation efforts.

These issues have led me to the following research questions:

1) What are Canadian undergraduate nursing students’ experiences of participating as learners in Indigenous health education?

2) What are students’ perceived facilitators and challenges as learners in Indigenous health education?

3) What are the implications of these educational programs for nursing education, research, practice, and policy?
Chapter Two: Literature Review

A comprehensive literature review was completed to locate materials related to Indigenous health content within nursing curriculum. Searches were completed in the following databases: CINHAL, PubMed, Scopus, iPortal, Nursing and Allied Health. Key words included “Indigenous,” “Aboriginal,” “Health,” “Content,” “Nursing,” “Curriculum”, “Canadian,” “Undergraduate,” “Bachelor Science in Nursing,” “Nursing Students,” “Learning Experiences,” and “Critical Ethnography”. Inclusion criteria included articles that were English, peer-reviewed, allowed access to full article, and an available abstract. Abstracts were read and filtered based on set above criteria. Criteria were developed based on the research question, the key concepts of the research work, and keywords that would enable a literature search pertaining to nursing students in undergraduate nursing programs. Key terms were searched individually and then with Boolean operators. Cited reference searching/bibliographic mining/backward citation was conducted throughout the search process. Additional grey literature that included news sources, textbooks, and unpublished articles were also included for their relevance. An overview of the Indian Act, impact of colonization, neo-colonialism, the problem of essentialism and culturalism, racism, current approaches, the truth and reconciliation calls to action, and necessity of students’ experiences will be covered.

Overview of the Indian Act (1876)

The Indian Act (1876) has both historically and presently imposed political force to segregate and enforce discriminative structures against Indigenous peoples (Schultz, Nguyen, Sinclaire, Fransoo, & McGibbon, 2021). The government designation of “Indian” became one of the most divisive and destructive aspects of the Indian Act. First, it divided the Canadian Indigenous peoples, the First Nations, Inuit, and Métis, into an arbitrary but devastating class
structure. Secondly, it created a schism between some reserve and urban Indigenous peoples. The term “Indigenous peoples” refers to three legally identified groups – First Nations, Inuit, and Métis under the Canadian Constitution (Richmond & Cook, 2016). Using this term can be misleading as it suggests Indigenous peoples within these groups are homogenous and not seen as diverse groups with varying belief systems, customs, cultural norms, and practices.

The overarching goal of assimilating Indigenous peoples into the “civilized Indians” included provisions mandated by the Canadian government that crossed social, cultural, economic, political, gender, and spiritual dimensions of Indian life (Richmond & Cook, 2016, p.3). Such provisions were established in treaty rights throughout 1871-1921 signed between the Canadian government and Indigenous peoples. However, despite the broad range of legislated provisions in exchange for land, the delivery of promises and treaty rights have been under the authority of the Canadian federal government (Richmond & Cook, 2016). This one-way colonial relationship, based on racial discrimination against Indigenous peoples, “set the stage for a debilitating, systemic public policy that continues in the modern day to powerfully shape patterns of [Indigenous] health, social inequity, and access to health care and other services” (Richmond & Cook, 2016, p.4). Indigenous communities continue to experience disproportionate burdens of poor health and health outcomes (Smye, Browne, Josewski, Keith, & Mussell, 2023) including “higher rates of infant mortality, tuberculosis, child and youth injuries and death, obesity and diabetes, youth suicide, and exposure to environmental contaminants” (Varcoe et al., 2016; Greenwood et al., 2018, p. 1646).

Impact of Colonization

Indigenous nations continue to face unrelenting systemic threats to their fundamental human rights (Kingston, 2015; Matheson, Seymour, Landry, Ventura, Arsenault, & Anisman,
Colonial activities, past and present, have attempted to take away Indigenous peoples’ cultural identity and land (Lavallee & Poole, 2010). For instance, the reserve system that was set up to relocate Indigenous populations to undesirable land for new settlers hastened the Canadian government’s monolithic mission and ensured perpetual access to and exploitation of their land and natural resources (Montford & Moore, 2018; Matheson et al., 2022). The residential school legacy whereby children were violently removed from homes, taken into abusive school environments, reprimanded for speaking their language and practicing their cultural teachings have resulted in cultural genocide for Indigenous peoples (Lavallee & Poole, 2010). Cultural genocide refers to “the purposeful weakening and ultimate destruction of cultural values and practices of feared out-groups […] with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group” (Kingston, 2015, p. 63, as cited in Davidson, 2012, p.18-19 and United Nations General Assembly, 1948, article 2). This was done through the intentional structural violence in the form of geographic displacement, taking away rights to practice cultural learnings, and banning sacred items used to conduct cultural ceremonies (Kingston, 2015; Knight, 2017; Varcoe et al., 2016).

Presently, the child welfare systems are still apprehending Indigenous children at an alarming rate in comparison to non-Indigenous children (Trocme, Knoke, & Blackstock, 2004; Matheson et al., 2022). Incarceration rates of Indigenous peoples in Canada are also disproportionate to non-Indigenous Canadians and serve as a strategic instrument of assimilation (Jacobs, 2012). Similar outcomes have occurred around the world and are continuing to cause significant trauma to individual survivors and collective communities (Lavallee & Pool, 2010).
(Neo)colonialism

Colonization is still ongoing. The idea of *colonization* as a static term and distinct event in past tense should be dismantled and stand corrected. Settlers come with the intention of staying in the nation-state, homemaking on their “property” or land, “and insisting on settler sovereignty over all things in their new domain” (Tuck & Yang, 2012, p.5). Settlers must destroy and rid Indigenous peoples on the land to build homes and create livelihoods. Settlers view themselves as holding authority over the land and its resources, thus leading to the extraction and exploitation of the earth (Tuck & Yang, 2012). Indigenous peoples have rich cultural histories that are tied to their geographic locations (Matheson et al., 2022). These geographic locations fostered a way of living and being for Indigenous peoples for centuries. The geographic displacement of Indigenous peoples has created multi-layered consequences in terms of cultural teachings and ways to life that are often passed down through experiential learning in relation to the specific nation’s environment (Tuck & Yang, 2012; Richmond & Cook, 2016). The disruption of Indigenous relationships to their land causes great “epistemic, ontological, cosmological violence […] that is reasserted each day by settler occupation” (p.5). Varcoe et al. (2016) assert that “the legacy of colonialism and systemic racism contribute to the current lack of employment opportunities, limited access to education, inadequate housing, and high levels of poverty experienced by Indigenous peoples in Canada, Australia, and other colonized countries throughout the world” (p. 545).

In settler colonialism, land is what is most valued, contested, and required. This is because Indigenous land can be made into homes and used as a source of capital (Tuck & Yang, 2012). For example, the properties built and sold, oil and mineral extraction, agriculture, and forestry industries, are exercised for profit, and degrade the earth’s land and natural resources.
Capitalism remains pervasive today which is why “settler colonialism is thus a structure and not an event” (Tuck & Yang, 2012, p. 6). Sylvestre, Castleden, Denis, Martin, & Bombay (2019) contend that “this fact must remain central when seeking to locate commonplace anti-Indigenous racism and its impacts on Indigenous health within the settler health care system” (p. 2).

*Neocolonialism* is a term used to describe the practice of capitalism, globalization, and cultural imperialism to influence the economic, political, cultural, and other areas of peoples’ lives instead of previous colonial methods of direct military control or political control (Google Definition; Sylvestre et al., 2019). It refers “to the forms of control embedded in policy and practice that allow for colonialism in present-day conditions” (St-Amant, Ward-Griffin, Berman, & Vainio-Mattila, 2018, p. 2; as cited in Reimer-Kirkham & Browne, 2006). Nursing as a profession is laden with policies and practices that have the insidious tendency to enact forms of neocolonialism. This is evident in clinical care practices, education, and research (Sylvestre et al., 2019).

Embedded Eurocentric and preconceived notions of who Indigenous peoples are play into the ongoing racial discrimination and Eurocentric attitudes toward Indigenous peoples in the face of social interactions and health care provision (Zeran, 2016; Hole et al., 2015). Health care professionals can be complacent and complicit in acts of direct and indirect racial discrimination, which consequently hinders the accessibility of health care services for Indigenous peoples (Hole, Evans, Berg, Bottorff, Dingwall, Alexis, & Smith, 2015; Smye, Joseowski, & Kendall, 2010; Sylvestre et al., 2019). Communication difficulties, racial stereotyping (as drunks and drug seekers), delaying care, making Indigenous peoples feel invisible, and not taking health concerns seriously, are few of the numerous realities for Indigenous peoples (McCalman, Jongen, & Bainbridge, 2017; Goodman, Fleming, Markwick, Morrison, Lagimodiere, & Kerr, 2017; Hole et
al., 2015). In a notable case in 2008, an Indigenous man – Brian Sinclair, was subject to the cruelty of racial discrimination at a Winnipeg hospital where he was ignored to death for 34 hours in the emergency room with an easily treatable infection (Brian Sinclair: Killed by racism, n.d.). Mr. Sinclair was falsely assumed to be homeless or “sleeping it off” by hospital staff who regarded him as “a shabbily-dressed Indigenous double-amputee in a wheelchair”. His racial profile and the held prejudice of hospital staff resulted in his death. This unfortunate case reflects systemic racism within a structure of indifference for Indigenous peoples in Canada.

In nursing education, neocolonialism is represented through common discourses and narratives about Indigenous peoples. In the Australian context, “media and school were the main sources of information perpetuating negative stereotypes” (Ramjan, Hunt & Salamonson, 2015, p. 205), however, it can be said that the Canadian context share this similarity (Goold & Usher, 2006). Education about Indigenous peoples’ histories, cultural diversity and ways of life are limited in euro-western education system (Ngunyulu, Sepeng, Moeta, Gambu, Mulaudzi, & Peu, 2020). Thus, it is not surprising that the trickle-down effect through education sustains these violent rhetoric’s for Indigenous Peoples (Hunt, Ramjan, McDonald, Koch, Baird, & Salamonson, 2015). It is acknowledged and further cautioned here that the reiteration of the negative stereotypes may also contribute to these violent discourses about Indigenous peoples. It is my intention here to increase awareness of the unsettling truths in which I am also implicated.

Neocolonialism is also evident in research. Despite the extensive research conducted in Indigenous health across disciplines and the increased knowledge about Indigenous health within the last several decades (Smith, 2012), Indigenous peoples still bear a burden of social and health inequities, including associated morbidity and mortalities (Goodman et al., 2017). Smith (2012) calls into question the value of researching Indigenous peoples and whether those who are
‘researching’ are primarily benefitting off the suffering and struggles of the ‘researched’ and in turn reinforcing (neo)colonial structures that further exploit Indigenous peoples. Smith contends that researchers “should not be building their careers by researching them [Indigenous people]” (p. 327), and that there are often associated implications and risks that must be considered when working in the “margins.”

Understandings of Culture in Nursing: Problems of Essentialism and Culturalism

Teaching about culture requires the examination of what has informed our foundation of understanding culture. Knowing the history of a term can help inform our understandings of how it is used and applied today (Marzilli, 2014). In nursing and healthcare settings, the term is relevant in that “an individual’s culture is determined in part by his or her home environment” (Marzilli, 2014, p. 228; as cited by Abraham et al., 2011). Exploring the meaning of culture and its evolution in nursing can provoke new ways of knowing the historical, political, and social factors that shape it. Culture should also be deemed relevant in nursing because “it threads its way through human behavior” and influences decision-making processes about health (Marzilli, 2011, p. 230). Nurses, as advocates and promoters of health, will need to be able to meet patient’s unique cultural needs.

Culture has commonly been understood as “a set of values, beliefs, knowledge, and customs that exist in a timeless and unchangeable vacuum” (Roy-Michaeli, 2011, p. 14; Browne & Varcoe, 2006). This view equates individuals to have a fixed cultural identity. It can also be synonymous to terms that include background, traditions, customs, and beliefs in the health care context (Marzilli, 2014). However, scholars have been adamant on expanding this definition to be more nuanced to enact cultural safety (Roy-Michaeli, 2011). In this pursuit, Wepa’s (2005)
definition has been interpreted by scholars to capture the conceptual breadth and depth as it relates to holistic aspects of the person:

*Broadly speaking, culture includes our activities, ideas, our belongings, and relationships, what we do, say, think, are. Culture is central to the manner in which all people develop and grow and how they view themselves and others. It is the outcome of the influences and principles of people’s ancestors, ideology, philosophies of life and geographical situation. Culture is never completely static, and all cultures are affected and modified by the proximity and influences of other cultures. (p.31)*

This definition further incorporates the social location and intersectionality of individuals and can necessitate further considerations for rapport building and respect for interventions considered important to individuals seeking care (Shannon et al., 2022). The accountability on the nurse or health care provider would be to ask and prioritize the individual’s and/or family’s preferences. Roy-Michaeli posits that nurses must be able to “recognize culture as a socially mediated process that is affected by historical and political factors” (p. 16) (Browne & Varcoe, 2006; Gray & Thomas, 2006; Vandenberg, 2010). However, in the literature, notions of essentialism, culturalism, universalism, and multiculturalism in nursing reflect a limited understanding of ‘culture’ for health care providers (Roy-Michaeli, 2011; Browne et al., 2016).

In essentialism, culture is perceived narrowly, “as something exotic that the other individual has, and the individual’s differences are based on stereotypes assumed to be the norm for the [collective] group” (Roy-Michaeli, 2011, p. 17). This is a common approach in nursing education whereby education on ‘cultural awareness’ stem from the perspectives of essentialism. For example, categorizing all Chinese Asians to have the diet of rice or an increased chance of having osteoporosis.
The culturalist perspective premises on the argument that “largely because of post-war immigration, there is now a society with a variety of groups which can be distinguished by their distinct cultures, that differ from the alleged majority ‘white’ culture (Culley, 1996, p. 565). This presumption lends way for nursing to develop the need for ‘transcultural care’ competencies to learn about the needs of people who are not in the (white) dominant group.

In universalism, culture is inexistent; cultural blindness expressed by Canadians equate to the perception that ‘everyone is equal’ (Roy-Michaeli, 2011). The paradox here is that while everyone is treated as equal, “culturally unique individuals and groups are viewed as different in the dominant society” (p.17).

A multiculturalist perspective reflects a reductionist view by “othering” the different culture (Roy-Michaeli, 2011). In this ideology, health care providers may be educated to better understand and respect cultures different from their own. “Appropriate education in this area, coupled with integration on the part of the more alien minority communities becomes the obvious solution to racialized inequalities in both health and access to health care” (Culley, 1996, p. 565). Within this discourse, problems of inequalities are attributed to ignorance or lack of understanding cultural differences, rather than being politically, historically, and socially construed. It is a form of neocolonialism, in which vulnerable communities are exploited for the purpose and benefit of white/majority group’s learning or becoming ‘culturally aware’. This implicates the further distancing of health care providers to critically reflect on their positionality and power matrixes existent in the nurse-client relationship.

Many educators are supporting the move away from these discourses in understanding and applying culture (Browne & Varcoe, 2006). Smye, Rameka, & Willis (2006) assert that nurses must challenge notions of culture to critically examine “how its structured by power,
sociopolitical, and historical events” (Roy-Michaeli, 2011, p. 11). To facilitate this mandate, educational institutions will need to increase access to curriculum about cultural safety, its relation to Indigenous health, and the detriments of racial biases in health care provisions.

When nurses think beyond cultural awareness and its essentialist approach to appreciate culture as a socially constructed entity, culture in the context of care will be taken up in a safe manner for patients in all cultures (Roy-Michaeli, 2011). In appreciating the evolution of the notion of culture and applications of culture through various perspective, it is a critical time to explore nursing students’ experiences of navigating this terrain in evolving their understandings of culture.

Deeply Embedded/Structural Racism

“Race”, a term originally misused to refer to one’s biological trait, has evolved to “be a social construct with political and social implications that many, including social workers [nurses], find uncomfortable to discuss” (Atkinson, 2010). In understanding racism, we need to visualize why it is significant in the context of Indigenous health.

Indigenous peoples make up 4.9% of Canada’s population. However, only 2.9% of the registered nursing (RN) workforce self-identify as Indigenous (Toulouse, 2014). This underrepresentation directly limits the access to decision-making power for Indigenous peoples. Self-determination, a cultural value, and principle in Indigenous self-governance, is therefore also limited.

In a narrative synthesis of the literature on medical, nursing, and allied health students’ experiences in placements in Australian Indigenous communities, McDonald (2018) documented nursing students’ increased awareness of everyday racism toward Indigenous peoples consistently. Most racist accounts were cited within qualitative studies, where quotes alluded to
how “students began to recognize their own prejudices and learnt how their past experiences shaped their beliefs and attitudes” (p.161). Of note were students’ incredulity at their direct experiences of racism “among health professionals and its relation to politics, stereotyping, and racism” (p.161). Studies in this review also pinpointed students’ newfound interests in pursuing professional careers in Indigenous health, however, a limitation was that there was no follow up regarding whether students pursued this area of work.

However, newfound interests should be exercised with caution, as there is a risk and potential of perpetuating white savior complex, whereby whites and/or settlers feel the need to “save” or “rescue” Indigenous peoples from the inequities created by colonialism such as the sub-par living and health conditions originally created by white settlers and their ancestors (Smith, 2012; Aronson, 2017). Another limitation is that all studies were in Australian contexts, therefore, transferability of findings may need to be further informed to appropriately apply to the Canadian context. Interestingly, despite this potential limitation, Smith (2012) posits that what takes place in another country’s knowledge synthesis, may be just as heavily weighted in contexts such as Canada, the United States, and New Zealand, where there is shared colonial histories.

Lane and Petrovic (2017) discuss how nurse educators should challenge their thinking, from the entrenched notion of “that was then, but those events should not impact my students now” mentality to move away from racial views and the discourses that continue to perpetuate the stereotype that adaptations made in school systems are “advantaging Indigenous students” (p.6). Martin (2006) shared similar findings in her critical ethnographic study on Indigenous nursing students’ experiences of learning in Canadian nursing schools, which found that nurse
educators are prominently situated in the ‘equality for all students and concessions for
Indigenous students could be perceived negatively as favoritism by others’.

Discourses of the ‘other’ as different (and inferior) were also noted in Foxall’s (2013)
study on Māori Indigenous student’s access, recruitment, and retention rates in academia.
Although this study was situated in the New Zealand context, nursing students’ experiences in
the Canadian context share similar barriers (Martin, 2006). Even if the students were recruited
and enrolled, retention within academia is poor due to lack of cultural and academic support,
family obligations, and financial hardship (Foxall, 2013). Challenges in recruitment and retention
are compounded by the social and health inequities that Indigenous students face. The undue
stress of navigating the western dominant system and balancing competing workloads of school
and home, speaks to the intergenerational impact of the Indian Act (1876) – a principle statue by
the Canadian Federal government known as a racist political regime to abolish Indigenous
peoples and their cultural ways. What has occurred has set the precedent of segregation of
Indigenous peoples through residential schools, the ‘sixties scoop,’ the foster care system,
chronic diseases, disenfranchised members in their own communities, and many preventable
hardships from lack of cultural security (Martin, 2006). Coffin (2007) defines cultural security as
the understanding of Indigenous cultural perceptions and ways to health, and incorporating their
self-determined decisions into actions that support an Indigenous person to feel safe to access
care (described as culturally safe care and determined by the recipients of care). “This is
concomitantly supported by organization or system-based policies and procedures […] designed
to be automatically applied from the time when Indigenous people first seek health care”
(Marriott, Strobel, Kendall, Bowen, Eades, Landes, Adams, & Reibel, 2019). Though Indigenous
peoples have profound resilience in the face of embodied trauma, the lineage of adverse events
continue to propagate unjust treatment of Indigenous peoples in all sectors of society. This privileges Eurocentric ways of thinking and ways to health (Hassen, Lofters, Michael, Mall, Pinto, & Rackal, 2021). Furthermore, racist attitudes and beliefs infiltrate Canadian society and continue the cycle of intergenerational trauma for Indigenous peoples (Menzies, 2008; Joy-Correll et al., 2022). Racism needs to be addressed, and it is time to shift our gaze unto every day and systemic racism in Canada.

Truth and Reconciliation – Are we there yet? What will it take?

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted in 2007 by most member states – except for Canada, Australia, New Zealand, and the United States. The four countries initially voting against have since joined in support of the rights proposed (United Nations, 2016). The declaration on the rights of Indigenous Peoples is a comprehensive instrument used internationally “as a framework of minimum standards on the rights of Indigenous Peoples” (United Nations, 2016). It is important to note the lag in timeline that Canada demonstrated before adoption of the declaration.

The Truth and Reconciliation (TRC) Report released in 2015 took six years to delicately piece together truth telling stories from over 6,000 witnesses and survivors. The TRC Report resulted in 94 ‘calls to action’ to address the health and social inequities (TRC, 2015). It was established in 2008 through a court-mandated settlement (Eisenberg, 2018). This is a pivotal time for nurses, as one of the largest health care professional groups, to seek ways to implement these recommendations as we move forward towards realizing an equitable and socially just future for Indigenous peoples and Canadian society. Calls to Action # 22, 23, and 24 are the focus of this study:
Call # 22: We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Call # 23: We call upon all levels of government to:

i) Increase the number of Aboriginal professionals working in the health-care field.

ii) Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

iii) Provide cultural competency training for all healthcare professionals.

Call # 24: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Implementing these three calls to action requires collaborative approaches to reconcile, decolonize, and Indigenize the nursing education system. Ultimately, the accountability of this work should be of concern for all members of society, especially within the nursing profession (Abercrombie-Donahue, 2011). Nursing’s ethical standards to promote client well-being and client choice through the values of respect for life, privacy, and confidentiality, maintaining commitments, truthfulness, and fairness coincide with the social justice vision of the Truth and Reconciliation Report’s Calls to Action (2015).
The 2006 court-mandated settlement to survivors of the residential schools was the largest class action lawsuit in Canadian history. The legal settlement included a ‘Common Experience Payment’ ($1.9 billion); an independent assessment process for individual claims ($1.7 billion); health and healing services ($125 million); the establishment of a TRC ($60 million); commemoration ($20 million); and the creation of a residential school archive, which was established in 2015 in Winnipeg, Manitoba, to house the proceedings of the Commission. (Eisenberg, 2018)

Even though there have been monumental achievements in fulfilling the calls to action, as displayed on ‘Beyond 94’ (CBC, 2018), there is still a long way to go (Lafontaine, 2018). In a published special report by the Yellowhead Institute, ‘Calls to Action Accountability: A 2022 Status Update on Reconciliation’, of the 94 calls to action, only thirteen have been completed in the last seven years (Jewel & Mosby, 2022). It has been noted that at this pace, it would take nearly 42 years to complete all 94 Calls to Action. This study aims to explore the approaches taken with Calls to Action 22-24.

Criticisms in relation to the Truth and Reconciliation Report reside on the processes that developed the report. Grey and Alison (2016) criticized the document for its lack of mention of gender, girls, mothers, female, or women and its lack of exposure to the gendered violence imposed through the Indian Act and residential schooling system. The authors go on to assert that Canada’s mandate “universalized and flattened the experience of [Indigenous girls and women]” and in instances where gender was mentioned was in relation to the residential school staff – “meaning that settler but not Indigenous experiences merited an intersectional analysis” (p. 315). Disturbingly, the consequential harms boil down “only pregnancy and abortion differentiate female and male survivors” (p.317). Other revealing examples reflected in the authors’ article
demonstrate the seeding of the patriarchy and displacement of women at a structural level. Thus, the truth and reconciliation’s report warrant a critical analysis in how it is also taken up by settlers who intend to be part of the reconciliation process.

Lafontaine (2018), an Indigenous anesthesiologist in northern Alberta, contends that as Canadians, “we have yet to make a broad, sustainable impact in closing Indigenous health disparities. We lack much of the data sets to even make this assessment” (p. 1). The federal government is primarily responsible for overseeing funds for Indigenous health initiatives. However, health and social services are mostly regulated by the provincial governments throughout Canada. This causes a disjointed approach in tailoring relevant priorities and projects that can serve Indigenous peoples (Deravin et al., 2018). What is needed is an effective, respectful approach in creating collaborative relationships with Indigenous peoples that empowers them to influence and self-determine decision-making processes at all levels of government (Deravin et al., 2018). This must be done with partnerships and processes in research, education, practice, and policy development.

Despite this, there is hope with the establishment of the Ministry of Indigenous Services (Indigenous Services Canada) by Minister Philpott (Lafonataine, 2018). It is hoped that this proposed study may contribute to informing health education, research, and policy to drive calls #22, 23, and 24 moving forward. Despite the desire, we cannot be too confident that people will do the right thing forever. Investigative means to gather relevant evidence is warranted to inform decision-making processes. As well, processes and outcomes need to bring underrepresented voices in from the margins to be in line with reconciliation efforts.
Efforts – Past and Present

In response to the prolonged health disparities faced by Indigenous peoples, explicit calls upon large sectors, including education, have been voiced. This has helped move the health agenda forward and improved equitable care for Indigenous peoples (Canadian Indigenous Nurses Association, 2009).

In New Zealand, cultural safety originated as a principle, concept, and framework of care to redress health inequities faced by Māori, the Indigenous people of Aotearoa. Cultural safety is in alignment with nursing’s legal, clinical, and ethical safety standards of care (Roy-Michaeli, 2011). Cultural safety extends beyond the notions of ‘cultural competence’, that suggests competency can be achieved in learning of another’s culture. Cultural competency has been defined as “a set of congruent behaviors, attitudes, and policies that come together in a healthcare system, agency, or professions to work effectively in cross-cultural situations” (McCalman, Jongen, & Bainbridge, 2017, p. 2). This definition is problematic and suggests an essentialist approach to learning about cultural differences (Smith, 2012). As previously mentioned, an essentialist approach is when culture is perceived narrowly, “as something exotic that the other individual has, and the individual’s differences are based on stereotypies assumed to be the norm for the [collective] group” (Roy-Michaeli, p. 17).

Cultural safety challenges this approach. Since the 1990’s it has transcended international boundaries (Smye, Josewski, & Kendall, 2010) and become a well-known principle in nursing and other health professions.

Despite the increasing awareness of cultural competency and cultural safety concepts, Guerra & Kurtz (2017) in their scoping review of cultural competency and cultural safety
education, posit that “few training and educational programs on cultural safety have been successfully implemented” in Canadian health professional education (p. 129).

Keeping their findings in mind, there is a critical shift away from cultural competency frameworks to cultural safety. However, there are still uncertainties of how cultural safety training translates into health care contexts. Some authors assert that culturally safe care needs to be an institutional effort. However, the full potential of cultural safety in repositioning Indigenous peoples in Canada require efforts on a micro, meso, and macro level. What this looks like, how it is approached, and how students are taking this up, need to be explored from a critical standpoint.

**Nursing Education – Students’ Experiences are Necessary**

Nursing education includes courses regarding the theoretical foundations of nursing so students can inform their clinical practice and begin to solidify their ways of knowing of the art and science in caring for others (Chinn & Kramer, 2015). Education is therefore a pivotal time to explore concepts of culture, power, privilege, social justice, equity, praxis, and emancipation, whether that is in the classroom or through experiential learning. Educational environments must also be conducive to facilitate student learning.

In Martin’s (2006) critical ethnographic study on Indigenous nursing students’ experiences at two nursing schools, findings revealed how euro-western ideologies and nursing discourse sustain the hegemony of nursing. Euro-western ideologies at its core inherently values individualism – idea of ‘self-management’, bio-medical understanding of health, paternalistic hierarchies in all systems, and knowledge from evidence solely derived from empirical sciences. Nursing education applies these values through the educators hired, textbooks, course materials, and resources used to educate nursing students.
Martin (2006) found that Indigenous students often feel marginalized by the dominance of western thinking and approaches in education that does not take into account other ways of knowing and being, including Indigenous knowing and being; this is an exclusionary practice because people experience marginalization. Having nursing students’ perspectives was significant in elucidating the lived experiences of being an Indigenous student in a Canadian nursing school and helped inform efforts to create culturally safe learning environments (Martin, 2006). The construction of Indigenous nursing students’ experiences later served to demonstrate the startling disadvantages Indigenous nursing students face due to the intersectionality of gender, race, culture, economic status, and geographical barriers (Martin, 2006).

In a systematic literature review on experiences and outcomes of health professional students undertaking education on Indigenous health, 12 articles originating from Australia, New Zealand, Canada, and the United States revealed four overarching themes (Mills, Creedy, & West, 2018). These included: “increasing knowledge of Indigenous health; emotional responses to content and teaching processes; perceived value of Indigenous health education; and cultural competence and critical thinking” (p.153). Diversity of experiences were well documented, demonstrating the value of student perspectives, in addition to recommendations made for education and research. Of note is the unclear nature of how increased knowledge for health care professional students translate into cultural capability to provide culturally safe care (Mills et al., 2018).

In Francis-Cracknell, et al.’s (2019) systematic review of Indigenous health curriculum and health professional learners, they found that cultural competence training “has potential to improve the knowledge, attitudes, and skills of health professionals,” (p.2) however, “no learning gains have been reported in changing institutional practice and impacts on health care outcomes”
Thus, these studies have demonstrated the value of exploring the current landscape of Indigenous health education and health professional students’ experiences of learning. As such, there is an imperative to conduct further research in exploring student and faculty perspectives to inform institutional changes, especially in regard to how Indigenous health content is taught, taken up, and facilitated.

**Problem/Research Question(s)/Objectives:**

1) To describe undergraduate nursing student experiences as participants in Indigenous health education.

2) To describe the facilitators and challenges to learning Indigenous health.

3) The findings will inform nursing education, leadership, research, clinical practice, and policy.

**Research Question:**

What are Canadian undergraduate nursing students’ experiences of learning Indigenous health?

**Sub Research Questions:**

What are students’ perceived facilitators and challenges of learning Indigenous health?

What are the implications for nursing education, leadership, research, practice, and policy?

**Prologue/Declaration of the Self/My Positionality**

My name is Ivy Tran and I am a Registered Nurse pursuing graduate studies – Master of Science in Nursing in the field of Health Promotion at Western University in London, Ontario. I identify as an Asian-Canadian settler with Chinese and Vietnamese roots and have personal experiences of racism in healthcare and at work. It was these unconscious internalized instances of racism and discrimination that continue to motivate me to pursue avenues that challenge the status quo and colonial hegemony of systemic racism. I acknowledge that my identity,
positionality, and socialization as a healthcare professional and academic and the person I am today has been strongly influenced by western-European knowledge systems. As such, my unconscious beliefs and value systems share similar alignment with systems and ways of thinking that continue to harm Indigenous peoples in conscious and unconscious ways.

The conceptualization of this study is based on my personal experiences of learning about Indigenous health from my undergraduate career, graduate studies, and personal nursing practice. My knowledge of Indigenous peoples was consciously first influenced by my exploration of an elective course entitled, Introductions to Indigenous Spirituality in North America. I came to appreciate new ways of thinking and practicing spirituality and ways to health, which consequently provoked my critical gaze into my own personal preconceived notions of Indigenous peoples. Although I am still learning, I acknowledge that I have gained a very deep appreciation of the cultural practices I was invited to partake in; the voices and resilience of Indigenous peoples; and takeaways in my personal interactions, relationships, and assumptions that impact the path toward reconciliation. In appreciating my greater self-awareness of my own racial identity and ways of thinking, I was propelled to learn more, and to continue the conversations of being an accomplice (refer to earlier section on definition of an accomplice – page 6) (Admin, 2016; Rich, 2019), and how health care professionals, and in particular, nurses, can play a role in being accomplices to facilitate anti-Indigenous racism and health promotion through a culturally safe, trauma-informed, and health equity lens with Indigenous peoples. The need to step out of my own comfort zone is rightfully so, and I share this with many colleagues and peers who feel similar emotions toward needing to do something but are unsure of where to start and how exactly is this supposed to be done. Thus, this study is a starting point in exploring the current state of Canadian undergraduate nursing education as I believe education is a political
act. However, in doing so, I am cognizant of the need to not overlook my own complicity “in terms of making representations of the ‘other’ and conforming to systems that reify the position of the colonizer” (Burke, 2017, p. 14).

Furthermore, my professional work in my graduate career have likely honed and developed my critical analytic thought processes about current realities of Indigenous peoples’ health and the need to collaboratively and ethically emancipate Indigenous peoples in Canada. I believe there is an imperative for “both Indigenous and non-Indigenous [peoples] to have access to good quality evidence on what teaching and learning strategies are required to ensure we are preparing graduates to work well in Indigenous health” (Francis-Cracknell et al., 2019, p. 1). In believing so, I have had the opportunity to take a graduate interdisciplinary course on Indigenous health and well-being through the Geography department with Dr. Chantelle Richmond, an Indigenous scholar, and other colleagues who have infused my thought processes with diverse perspectives and approaches to Indigenous health. From a professional standpoint, my assumption is also that it is a moral duty to learn and apply the available knowledge and expertise, those of my own learnings and with permission and inclusion of Indigenous peoples’ expertise to bring upon socially-just processes and outcomes for Indigenous peoples in Canada. Luckily, I am very fortunate to pursue my graduate studies, where I have the safe and brave space to make inquiries (that may be contested) and engage in conversations with Indigenous and non-Indigenous voices and scholars about promoting health and changing the system in small, but pivotal, steps. These are small gradual steps that I am not alone in working towards, as I have been fortunate to be influenced by the nursing scholars and leaders that share this vision and graduate study journey with me.
Chapter Three: Methodology/Design

Theoretical Framework – Postcolonial Theory

It has been acknowledged that nursing scholarship drawing on critical theories has “considerable potential in addressing the social mandate of nursing by lifting analysis beyond micro level to an examination of the complex socioeconomic, historical, and political nexus in which human experience is embedded” (Kirkham & Anderson, 2002, p. 2). Postcolonial theory, founded by Edward Said (1978), provides a lens that allows “access to the everyday experiences of marginalization, as structured by the micro politics of power and the macro dynamics of structural and historical nature” (Kirkham & Anderson, 2002, p.2). Other important postcolonial critics include Frantz Fanon (1952), Homi K. Bhaba (1994), Gayatri Chakravorty Spivak (Sawant, 2011). It is important to note that the term postcolonial can be referred to a distinct historical period in which European countries achieved political independence and power through colonization (Walker, 2017). However, given that postcolonial theories are “a family of theories sharing a social, political, and moral concern about the history and present-day legacy of colonialism” (Browne, Smye, & Varcoe, 2005, p. 19), it should be made clear that the term ‘postcolonial’ does not mean that colonialism is over. It is still occurring in modern day and does not have an end point (Walker, 2017). Marie Battiste (2011) asserts that, “Eurocentrism and colonialism continue to dominate the global landscape at individual, social, systemic, and epistemological levels, and as such, postcolonial theory rejects and challenges notions of eurocentrism and colonialism” (Walker, 2017, p. 43).

Postcolonial theory differs from theories of critical theory in that it focuses on “disrupting the history of ‘race-thinking’ and the structural inequities that have been brought about by histories of colonization and by ongoing neocolonial practices” (Browne et al., 2005, p. 22).
This, in turn, provides a powerful analytical framework and vocabulary to thinking about health and human suffering in the socio-historical-political context.

Given the colonial history in Canada, critical ethnography informed by postcolonial theory was used to explore the experiences of nursing students taking Indigenous health content. The use of postcolonial theory in this study promoted inquiries into the fluidity of cultural spaces where negotiation of culture, power, and privileges between the colonizer and the colonized came to fruition (Anderson, 2002, & Downing, 2010). Postcolonial theory has been a slow growing influence within nursing scholarship; however, there is an increasing call for “integration of postcolonial perspectives as an alternative to the culturalist approaches that predominate nursing theory” (Kirkham & Anderson, 2002, p. 2). Postcolonial theory asserts that underlying processes that foster understanding about cultural identity formation and “the ways in which discourses of culture and cultural knowledge are used by colonial systems to obtain and maintain the power of the dominant culture” must be understood and applied, versus simply gaining “cultural awareness” of the other through education on essentialist perspectives (Downing, 2010, p.16).

Such cultural awareness/essentialist education on differences of the other perpetuate the binary or dualistic discourses of the other, which have been and continue to be particularly harmful to Indigenous peoples (Walker, 2017). Postcolonial lens was used to inform my analysis of the culture of nursing education and pedagogy in relation to how students experience such learning to inform their own discourses of Indigenous health. The resultant themes were helpful in explicating important points of discussion to make practical changes in nursing education.
Methodology – Critical Ethnography in Nursing Research

Critical ethnography is becoming increasingly used in nursing research (Smyth & Holmes, 2005). The methodology has been used in a variety of contexts. For example, Laging, Kenny, Bauer, and Nay (2018) used critical ethnography to explore factors that influence nurse’s recognition and assessment of resident’s deterioration in nursing homes. The findings highlighted the internalized historical image of nurses to be that of a “doctor’s assistant” and its effects in untimely assessments, vulnerability, and isolation advocating for care interventions based on assessment findings (Laging et al., 2018).

Another study revealed how health care providers were influenced to perpetuate dominant care ideologies in the Intensive Care Units based on reductionist and paternalistic attitudes in the nation's culture (Bidabadi, Yazdannik, & Zargham-Boroujeni, 2017). The use of critical ethnography helped to increase healthcare professional awareness and critical self-reflection to advocate for managerial authorities to consider ethical approaches in lessening care provider burnout. Implications from this study served to benefit intensive care unit patients as it addressed the gap of value (dignified care) and action (lack of confidentiality and shameful practices from care provider burnout) (Bidabadi et al., 2017).

Carspecken (1996) asserts that researchers should be concerned about the very nature of power within a social system (Smyth & Holmes, 2005). Smith (2012) notes that research itself is a powerful intervention, one that privileges researchers with information that can be interpreted overtly and covertly. However, sometimes such privilege comes with the unintentional power to also “distort, to make invisible, to overlook, to exaggerate and to draw conclusions, based on not factual data but on assumptions, hidden value judgements, and often downright
misunderstandings” (Smith, 2012, p.290). Critical ethnographers are thus reminded to be critically self-reflective of and reflexive with their inherent power as well.

Lastly, the promises of critical ethnography are evidenced in Martin’s (2006) study on Indigenous nursing students’ experiences of learning at two Canadian nursing schools. Through observations and interviews and textual analysis, issues of recruitment and retention of Indigenous nursing students were addressed and concluded with implications for nursing education. Critical ethnography holds great promise for researchers seeking to further their depths of inquiries on broader societal issues. This methodology, as stipulated by Smyth and Holmes (2005), serves an emancipatory intent, and aligns closely with nursing’s contemporary ways of knowing (Chinn & Kramer, 2015). Critical ethnography will continue to grow in its use as implications benefit nursing knowledge and practice. Although the merits of critical ethnography are highlighted here and serve to be emancipatory from my understanding, it is critical to note here that it is not an Indigenous methodology, and other methodologies could and should be explored to situate this work. The next section will unpack critical ethnography more explicitly.

Use of Critical Ethnography

In this study I employed critical ethnography (CE) methodology and associated methods that include in-depth semi-structured individual interviews. Critical ethnography is a social science research methodology that integrates critical theory into ethnography (Thomas 1993, Howell, 2013, & Ryan, 2017). Critical ethnography is employed to understand cognitive and behavioral processes from a cultural lens; unpack implicit biases, systemic mechanisms of power, and cultural phenomena; and address the praxis of unjust findings (Carspecken, 1996; Hardcastle, Usher, & Holmes, 2006).
Critical ethnographers consider how participants and communities are represented, and how such representations serve to be repressive, unjust, and controlled (Ryan, 2017). Such considerations serve as a more realistic approach in terms of understanding ‘why’ things are the way they are, rather than simply describing things the way they are. Schools of Nursing are a culture in and of themselves (Walker, 2017). They uphold ideologies and ways of approaching care that need to be challenged if things are to change in relation to Indigenous health. Critical ethnography further moves away from traditional forms of ethnography, where the researcher plays a more participatory role in interpreting the circumstances of those researched, the effects of research, and thus, requires close attention to reflexivity (Ryan, 2017). Carspecken (1996) asserts that “alterations in participant behaviour usually do not correspond with alterations in the cultural milieu” (p. 52), and it may not be possible or desired for researchers to be in positions of passivity within the research work (Hardcastle et al., 2006).

A critical ethnographic approach requires that investigators be open, honest about their implicit biases, and keenly aware of how each decision and action/inaction may impact the informants, Indigenous peoples, and communities involved through each stage. For example, Crow (1993) argues that implicit values of time orientation, individualism, competitive spirit, among other Eurocentric value-laden approaches to nursing education have created undue burden of acculturation for minority groups seeking nursing education in euro-western learning environments. As a researcher and former nursing student educated in a euro-western nursing program, I am keenly aware of the implicit values that may have to be challenged in order to approach this research work in an open and honest way. For example, the value of ‘time orientation’ can be subconsciously applied by the prescribed ’30-60 minute’ timeframe proposed in the study. In retrospect, this decision may have impacted informants to limit their responses.
and divulge less than they would have. For interviews that went beyond 60 minutes, I would inform the informants that they can continue as they please, but I also made sure the informants were aware I was also respectful of their time and other commitments. This pause and reminder about the time at the 60-minute mark may have halted important developments informants would have potentially shared had there not been a subconsciously prescribed timeframe.

Critical ethnography offers an emancipatory purpose for both the researched and the researcher (Carspecken, 1996, Harcastle et al., 2006). It is intentional in provoking “social change through raising awareness of oppressive power structures […] to challenge them and bring about change” (Ryan, 2017, p. 19). This aligned closely to the research purpose, the research questions, in which, implications for schools of nursing, and other domains of nursing were drawn.

Methods

Study Setting

The study took place across four Canadian post-secondary institutions that have Baccalaureate nursing programs. The schools of nursing were in the provinces of Ontario, Saskatchewan, and British Columbia. The purposive selection of nursing schools that work closely with Indigenous populations was pertinent to this study because this study aimed to explore learning experiences of Indigenous and non-Indigenous nursing students taking courses with Indigenous health content and/or Indigenous health courses. It is assumed that there will be a higher enrolment of Indigenous students within four of the programs who can be unique informants in this study, as they have the lens of their respective Indigenous backgrounds and that of being a nursing student. It is key to note here that two of the schools also have Aboriginal Equity Access Program, whereby a percentage (16.6% and 10%, respectively) of seats for the nursing programs are reserved for persons of Indigenous ancestry. One University also has a
long history of Indigenous student success and is recognized as having the highest number of Indigenous nursing students in the country. Another university also has a bridging program (Native Nursing Entry Program) designed for Indigenous students to develop necessary requisite skills and academic preparation to ensure success in the Bachelor of Science in Nursing (BScN) program.

The contact for one Ontario University was sought through the Council of Ontario Programs in Nursing (COUPN), where the researcher’s supervisor is a current member and could make formal connections with school of nursing leaders at the University’s. Three other universities were contacted through the researcher’s supervisor as well, as mutual connections already existed and could be leveraged to help champion this study. Mutual connections lend to the feasibility of the study as technology prompted the initial partnership with the research member. Once initial connections were made, the schools of nursing administration were contacted for formal permission to contact students regarding this study. The letters, posters, and letter of information were sent to the school’s academic counsellor, school administration, or office staff to forward to students via e-mail mass messaging.

Permission for the study was sought through Western’s University Ethics Review Board and one of the university’s Ethics board. The three other schools were informed about the ethics approval and were sent a copy of the Ethics Review Board Approval.

Participants

Eligibility criteria.

Undergraduate nursing students who have either undertaken courses that include course content on Indigenous health or individual Indigenous study courses were recruited to participate as informants in this study. BScN nursing students in collaborative and compressed time-frame
programs were sought to ensure a breadth of student perspectives. Similarly, Schools of Nursing in Ontario and western Canada were contacted to recruit students to ensure geographic spread and the inclusion of Indigenous and non-Indigenous perspectives. An equal balance of Indigenous and non-Indigenous perspectives was the goal.

Faculty/Professors who taught Indigenous health content in any capacity were also recruited as informants to add to the triangulation of data. Instructors were prompted to reflect upon their own approaches and the perceived facilitators and challenges of teaching Indigenous health content. It was expected that they would provide critical insights that may be helpful in creating discussion about social change in the learning environment in which they co-created learning.

**Sampling strategy.**

As previously mentioned, four Canadian Undergraduate Schools of Nursing were contacted to recruit three to four nursing students within each school. It was found in an exploratory study that 12 participants is a sufficient sample size for qualitative studies conducting a thematic analysis (Ando, Cousins, & Young, 2014). However, for this study, the sample size was considered sufficient once saturation was reached. Nursing students provided an in-depth account about their learning experiences of Indigenous health content and the current nursing education curriculum. Triangulation with faculty or professors who taught the course content on Indigenous health were also asked to participate as informants in this study.

Faculty added a unique perspective in that they were able to provide insights on their observations of nursing students learning Indigenous health content. The triangulation of this data was able to reflect a more representative understanding of the pedagogical and learning processes, where the goal was to find “observable patterns of behavior, belief, ideas, and rituals
shared by members of the school community,” as called upon by the critical ethnography methodology (Abercrombie-Donahue, 2011, p. 67).

A purposive sampling strategy was used to recruit study participants. Purposive sampling is the purposeful selection through specific criteria of participants instead of random sampling. The study sample were chosen because they were best suited to answer the research question. Informants in this study were purposefully targeted with intent and participation was on a voluntary basis. This sampling strategy is often used within qualitative studies to yield the most appropriate sample that would be the best informants to the research question one is investigating (Tuckett, 2004). It fits with the methodology of critical ethnography as critical ethnography requires the key informants who can answer the specific context driven questions in an honest and in-depth account.

Schools of Nursing received a letter email (Appendix C) regarding the study’s purpose and design, contact information about primary investigator, and were provided a link to access online consent forms, should students or instructors/professors be interested to participate. Electronic posters were also sent to allow Schools of Nursing to disseminate along with the study’s letter of information and consent form. Schools had the option to post in their hallways, office doors, elevators, and clinical labs to increase chances of raising awareness about study.

To demonstrate interest and intention to participate, students and faculty could contact the primary investigator at a designated email. Students and faculty/professors received a website link from the research investigator to an online portal that allowed them to view detailed information about the study (Appendix D) and questionnaire to complete for eligibility criteria (Appendix E). Upon meeting eligibility criteria, the participants were invited to complete a voluntary demographic survey (Appendix F) and chose from several dates for telephone or
virtual interviews with the investigator (research member – MScN student). The recruitment period took place between May 2020 to March 2022, with interviews taking place within 1-4 weeks after. After transcription and analysis, the informants were followed up with again for member checking. Member checking will be elaborated on in a future section on validity.

Individual semi-structured interviews ranged between 20 minutes to 90 minutes.

Nursing students and faculty/professors had the right to withdraw consent at any point in time throughout the study and were reminded as well by the research team member. Withdrawal of consent from this study meant there would no longer be further data collection, however, the use of the unidentifiable data will be used in the analysis and results.

Participant Demographics

Six undergraduate nursing students participated in this study. Five students participated in the demographic questionnaire. Two students were between 18-21 years old, two between 22-25 years old, and one between 26-29 years old. Three students identified as female, one male, and one other. Four were born in Canada and one was born outside of Canada. Two students self-identified as Indigenous, two did not identify as Indigenous, and one chose not to answer. Five of the students were in the collaborative baccalaureate nursing program, none were in a compressed time frame program. Two of the students were in their second year of a four-year program, two were in their third year, and one was in their fourth year of studies. Of the five student respondents to the questionnaire, only two had previously taken an Indigenous health course – both stated that it was mandatory.

Three faculty participated in this study. All three were female, self-identified as Indigenous, and have experiences teaching Indigenous health through mandatory courses pertaining to Indigenous health and/or content on Indigenous health within nursing courses.
Data Collection

Although ethnographies traditionally involve observations and interviews, only semi-structured interviews were used as method of data collection due to the COVID-19 pandemic and restrictions to travel and in-person interactions. Observations were approved by Research Ethics Board (REB) as it would have provided the opportunity for the research member to be immersed in the learning environment and gain contextually unique understanding of the culture of the classroom/education settings where Indigenous health education may take place.

Participant’s demographic information was collected through the initial demographic/screening questionnaire. Individual semi-structured interviews was the method chosen under the critical ethnography methodology because it would enable students and faculty to share opinions and storylines (Lind & Smith, 2008) based on their experiences of learning and observing learning of Indigenous health content respectively. Interview guides (Appendix A) were developed to guide the interviews, however, the research member, ultimately remained flexible and followed each participant’s flow of responses. Participants were encouraged to talk about anything they felt was relevant to this study. This method provided diverse perspectives to purposefully paint a larger picture of the critique this study aimed to elicit on the current education of Canadian undergraduate nursing students with regards to Indigenous health.

Member checking was utilized to ensure the perceptions of informants were captured accurately. Where possible biases may have existed, the investigator made attempts to ensure these are explicit and informed the research in an authentic manner.

Audio recording was used as it was appropriate to ensure ongoing discussions took place without interruptions of written recording. Audio-recorded responses was later transcribed verbatim and replayed as needed to get a sense of the reaction or pick up missed dialogue.
Audio-recording required the informed consent of the participants and was also password protected and/or stored appropriately in online portal (OneDrive) that only the research member had access through. Once the recordings were transcribed and saved, the recordings were deleted from the audio recording device.

Data Analysis

An interpretive thematic analysis was completed using processes described for qualitatively derived data (Braun & Clarke, 2006). Abercrombie-Donahue (2011) propose the ‘description, analysis, and interpretation approach advocated by Wolcott (1994) for data analysis of ethnographic studies. In ethnographic work such as this, the stages of data collection and analysis do not occur in a linear fashion but rather are iterative processes. For the purposes of this study, however, I identify the following steps in guiding my data analysis:

Step 1: As interview data (audio recordings) were collected, they were transcribed verbatim by myself and a nursing colleague, then checked for accuracy against the original audio-taped versions by me (the researcher). All transcripts were de-identified to ensure anonymity. Interview transcripts were sent to informants with the option to review and add, change, or omit responses before coding began.

Step 2: Each transcript was given a half-page to one-page summary based on the research member’s initial impressions and descriptive summary of the informant’s experiences. As data continued to be gathered, whole interviews were read repeatedly by me (the researcher) and several were shared with my supervisor to identify recurring, converging, and contradictory patterns of interaction, key concepts, preliminary themes, illustrative examples from the data,
and possible linkages to theory. As part of this process, coding categories were revised and refined.

Step 3: As more data were reviewed and coded, emerging concepts and themes were further explored using a Postcolonial theoretical lens. For example, particular attention was paid to the factors that shaped student and faculty/professor experiences of learning and teaching Indigenous health education, respectively, the facilitators and challenges associated with this experience and what constitutes a safe and effective learning environment.

Step 4: Using comparative coding, independently coded transcripts were compared to identify similarities and differences. This method addresses discrepancies in coding by either including varying interpretations and cross-referencing or by developing new coding categories. Discrepant interpretations also could identify areas for further exploration by the researcher. Reflective discussions about the data are critical to the analysis to draw distinctions between personal feelings and analytical descriptions. Here the interviews with students and faculty assisted in elucidating complex intersecting factors that shape experience race, pedagogy, and faculty preparedness. This step also included asking participants if they would like to further explore their transcript to explore additional ideas arising from the analysis.

Step 5: Exemplars from coded categories and themes were compared within and across transcripts to take the data to a higher level of conceptualization and generate broader theoretical constructs or propositions.
The goal is to move analytically between the data and theory so that there is a relationship of reciprocity between the data, informants’ perspectives, including Indigenous perspectives and the emerging theoretical perspectives. Analysis continued until the research team developed a synthesized account of student and faculty experiences of the factors shaping their learning and teaching and the influence those factors on safety/un-safety in the classroom.

In terms of coding schemes, Polit and Beck (2016) note that “developing a high-quality coding scheme involves careful reading of the data, with an eye to identifying underlying concepts. Important concepts that emerge from close examination of the data are then given a label that forms the basis for a theme” and/or category. In coding the qualitative data, new themes may emerge, and in that case the entire responses will be re-read and re-coded accordingly (Polit & Beck, 2016).

The data was analyzed by a ‘constant comparison method’ (Glaser & Strauss, 1967) of the differing groups (i.e., Student responses, Indigenous and non-Indigenous, and faculty responses) to gain insight on inter group similarities and differences by making systematic comparisons across units of data (Ryan & Bernard, 2003).

Similar to Abercrombie-Donahue’s (2011) approach, inter and intra group comparisons were re-analyzed to explore variations and highlight codes/themes that stuck out “both within and across groups”. The data was triangulated to identify prominent patterns while concurrently acknowledging the “intra-group diversity” of shared experiences. Consistent with critical ethnography, data was analyzed to shed light on the individual experiences and applying explanatory analysis relevant to the social and political structure to emulate the ethic and emic perspectives used in critical ethnography.
Ensuring Trustworthiness, Validity, and Reliability

As suggested in Abercrombie-Donahue (2011), “ethnographic researchers should establish trustworthiness of their data collection and analysis by collecting a weight of evidence that can demonstrate the trustworthiness of their conclusions” (p.73). This was approached by triangulating multiple data sources, that of nursing students and faculty, which helped to increase the objectivity of the data.

To enhance validity, Smyth and Holmes (2005) cite Carspecken’s (1996) suggestions of member checking and peer debriefing.

*Member checking: involve participants in checking the researcher’s meaning reconstructions to help challenge the researcher’s understanding*

*Peer debriefing: researcher’s biases or absences in reconstructions are checked*

*(Smyth & Holmes, 2005, p.70)*

Reliability “is about agreement among coders and across methods and across studies” (Ryan & Bernard, 2010, p. 72). This was approached through member checking, as personal reconstructions and interpretations of codes were ‘checked’ to confirm with informants, who had the choice to change such reconstructions of the research team members’ interpretations. A journal and an excel log of validity checks were also kept to track all measures to enhance trustworthiness, validity, and reliability as the study progressed.

Member checking was done by sending transcripts to all informants to allow for a read-over and the opportunity to ensure its accuracy. Informants were also able to add additional thoughts, change their responses, or omit any responses they were not comfortable with. All quotes used in the Findings section and its interpretations were also sent to participants to confirm interpretations made. One participant’s request to alter some quotes were taken into
account. Secondly, after the findings and analyses were completed, the research team member delivered individual and small group presentation to nursing students and faculty who were not originally apart of the study to elicit feedback and to explore if the findings resonated with them as well at a national nursing education conference poster session.

Peer debriefing was conducted at a national nursing education conference whereby other researchers and presenters were able to interact with the research poster made by the research team member (master’s student). Individuals had a nursing background but were not particularly familiar with the research, transcripts, methodology, or findings. Feedback was considered and validated by some nursing student researchers and PhD candidates. The manuscript draft was also provided to the research team member’s connection to a local sociology researcher and professor to provide feedback and point out inconsistencies between methodology, findings, and limitations.

**Ethical Considerations**

The author of this study maintained ethical responsibility in preparation, during, and post study in the design, sampling strategy, and dissemination of the results; and all protocols involved. This study highlights ways the ethical principles were upheld through the Review Ethics Board.

**Ethics Review Board**

Research ethics approval was obtained from the Non-Medical Review Ethics Board at Western University, where the researcher member’s thesis work began (Appendix G). The informed consent included that eligible informants for this study had access to the primary investigator’s contact, online portal with study information, and were able to ask for ongoing consent to participate (Bidabadi, Yazdannik,& Zargham-Boroujeni, 2017). Informants also had
the right to refuse answering certain questions that they find uncomfortable or difficult to answer. The risks, benefits, and details of the study were included in a comprehensive letter of information and consent.

Study informant’s privacy and confidentiality were regarded highly by ensuring audio-taped/phone recordings are saved on OneDrive, a secured online drive that is password protected. Audio-recording device was stored in a locked drawer in the research team member’s workspace at home. Interview recordings were deleted off device once file was saved into OneDrive. Similar to Martin’s (2006) doctoral work, all data were de-identified and labelled with NS1, NS2, NS3, or F/I1, F/I2, F/I3 and so forth to protect names and identities of students and faculty. Transcription data and analysis documents were also stored in the OneDrive.
Chapter Four: Findings

Six nursing students and three faculty members participated in our study. Despite the overall breadth and depth of discussion on students’ learning and faculty’s teaching experiences, only poignant themes will be discussed for the purpose of this research work. Based on the informants’ accounts, we identified five overarching critical themes with accompanying subthemes relevant to nursing and faculty experiences of learning and teaching Indigenous health education. The themes chosen were led by our literature review, postcolonial theory lens, and informants’ responses demonstrating their learning processes and notions of culturally safe or unsafe learning. The research team acknowledges that our assumptions and implicit biases have impacted the themes chosen as well. However, the semi-structured interviews may have also contributed to the themes elicited. The five overarching themes are as follows: (1) Encountering racism in education and practice, (2) Need for faculty development, (3) Decentering whiteness in the classroom, (4) Creating cultural safety in the classroom, and (5) From classroom to practice (Appendix B). Subthemes will be discussed within each of the overarching themes.

Theme 1: Encountering Racism in Education and Practice

In describing their learning experiences of Indigenous health content, some nursing students referred to both in-class and clinical situations where Indigenous Peoples were subjected to stereotyping, prejudice, and racialization. The three subthemes include the theory to practice gap, racism in education, and racism in practice.

1.1 Theory to Practice Gap

In response to the broad, open-ended question of their experiences of learning, students automatically described their inability to put into practice their learning of concepts such as cultural safety, cultural competence, and/or cultural humility (to name a few). A nursing student
recalls her experience of learning about culture as a dynamic and everchanging construct, one that can expand beyond the traditional understandings of culture as a “set of beliefs, values, and/or religion.” This notion of culture was not what the student experienced in their nursing practice. In the example below, a nursing student speaks about the institution’s documentation system for nursing care and how culture is assessed, applied into practice, and documented:

So I wrote “patient denies” in the [check]box [on the health assessment form] but I didn’t check no? Yeah, I feel like it’s kind of just like a component to include in your care plan.

It’s just a [cultural] box you check off yes or no. – NS5

The student felt the check box implied that patients either had ‘culture’ or not. The student further elaborated that the culture question rested solely on if there were cultural practices the patient would prefer to be incorporated in their health care plan. Classroom learning did not always translate to what the students applied or saw in clinical practice. Here the student highlights the problematic nature of essentializing ‘culture’ to that of racialized people, which further reduces racialized people to their ‘cultural practices.’ Although culture is taught one way, in health care, it often is taken up differently.

The student also speaks to the classroom learning of minority groups as “hypothetical” and the normative whiteness,

There has to be a shift that happens away from talking about minorities as a hypothetical. Um, even someone brought up recently the mannequins that we practice on – they’re always white. No mannequins with different skin color. Our textbooks, there’s always special sections for different cultures in each chapter and it makes it feel like one, they’re being forced to include it, two, it’s not the normal it’s not – like it needs a separate section. So I think there just needs to be continued awareness of things like that and like work toward fixing it – NS5

Here the student highlights the normative whiteness inherent in nursing education – in the resources used to the simulated mannequins used in practicing healthcare interactions. The
student hints at the underlying systemic racism that is covert in that whiteness is the norm, and race or cultural group other than white, is considered different and compared to the baseline of whiteness. In practice settings, patients are from all different backgrounds and should be reflected in the classroom learning as well.

Some nursing faculty also spoke about the notion of ‘culture.’ When asked about the faculty’s perceived challenges related to students’ learning of Indigenous health, a nursing faculty stated the following,

Really, every single person that I’ve worked with in the field, in First Nations communities, when there is a complaint of how they were treated, it certainly is not because they were not able to smudge in the hospital, or that there was some, you know, cultural faux pas, it's ultimately about a racist attitude, or being, you know, ignored, silenced, disregarded, undermined, undervalued, put in their place, as less than - there's been a power differential, all of those things that relate to more of a critical theory foundation, than a cultural approach [to care]. And so that would be a really big challenge is that I think sometimes people think that adapting an Indigenous health course, is about incorporating cultural components into the curriculum - and those are fine and can be part of it. But the essence of any course needs to be from an anti-Indigenous racism, jumping off point. – NF2

Cultural practices are conflated with being culturally sensitive, culturally competent, or ‘culturally safe’ in practice. Although the inclusion of cultural practices within Indigenous health education can be well-intentioned, racism in health care goes beyond that. Here the faculty member points to the need to shift our attention from the culture of the ‘other’ in nursing education to focus on excellence in relational practice through an anti-racist lens. The faculty also highlights the critical theories that may necessitate discussions around power imbalances within nursing, which may facilitate integrating an anti-racism lens in education and practice.
1.2 Racism in nursing education

Nursing students have noted that educators such as nursing faculty have made stereotypic comments related to Indigenous peoples while teaching Indigenous health. For example, a nursing student recalls,

“Like the prof would say “they [ Indigenous Peoples] put their babies in cradleboards and then their babies get flat head so when you’re doing physical assessments on infants, watch out for flat heads with native babies”. Right? Like it’s just these kinds of things [laughs] are not only wildly inaccurate because you’re only exclusively speaking from your own personal experience but like they put ideas into student’s heads that result in racist assumptions when you go out and you begin your practice as a student nurse.” – NS2

Despite the student laughing, her description of a teacher who presents inaccurate and deeply racist beliefs as “fact” (babies get flat head”), as well as the racist term “native” babies) is shocking. Here a nursing student conveyed that individuals teaching Indigenous health can be complicit in furthering the racialization of Indigenous Peoples by intentional or unintentional remarks of microaggressions, stereotypes, essentializing, and taking personal opinions out of context. Racist remarks may be covert and perpetuate harmful narratives if left unchallenged.

1.3 Racism in practice

Nursing students highlighted examples of bearing witness to acts of racialization and racial discrimination of Indigenous patients during their clinical placements – specifically in the hospital setting. As one student noted,
“I had a nurse talking about how one patient was probably in the hospital because she was having drug seeking behavior and then checks the last name to see if it’s an Indigenous person.” – NS5

Racism in practice is ingrained in the healthcare system that it is taken for granted. A nursing student described the dilemma of being a bystander to these racist incidents and were uncertain to how they should approach speaking up about it. Bystander phenomenon may occur due to power differentials and students’ inability to speak up while bearing witness to racial discrimination. This emphasizes the gap between in-class learning and practice when it comes to Indigenous health. These instances affirm the need for anti-racist placement/work setting policies and procedures need to be established and discussed with nursing students prior to the beginning of their clinical placements.

Theme 2: Need for Faculty Development

The need for faculty development was the second theme that emerged on several occasions for both nursing students and nursing faculty and included three subthemes: 1) Lack of representation, 2) Faculty’s preparedness and knowledge on Indigenous health, and 3) Racial identity development.

2.1 Lack of representation

A few nursing students felt one of the challenges to learning Indigenous health was how Indigenous persons are tokenized in the classroom. Nursing students or faculty who identified as Indigenous were often homogenized and expected to speak on behalf of Indigenous peoples. As one student noted in the following,

It’s almost like there’ll be one member of the faculty that’s Indigenous and like you know, it’s as if she’s like tokenized. Because she’s the only person that I have ever seen brought in. And I had - so she’s taught one course of mine, and then then she guest lectured in two other courses on Indigenous health, and it’s like are you, that’s great -
that’s wonderful, she’s obviously in touch as a nurse practitioner, she, you know, she is super educated and experienced but like she’s not the only person here…it’s odd to me that you would continually go back to the same person over and over again who, who, yeah… I don’t know, I don’t know her personal experiences but like I don’t know. - NS2

Here the nursing student appreciated having Indigenous voice and representation, however, it was also conveyed by other students that having one Indigenous faculty was problematic and highlights deeper issues in the institution, e.g., the lack of Indigenous people (ie, hiring practices). In a similar but slightly different vein, another student speaks to this in the following,

I think a lot of people [faculty and students] are like, well, why don't we just ask the Indigenous students and like, I wouldn't want to if somebody asked me like, “Hi do you want to talk about your experience of like racism you witnessed in your life in front of the whole class?” I'd be like, No, I don't want to talk about that! Like it's, it's really important to focus on like, the [Indigenous] people who are [there and want] to talk about that and like that their goal is to share their experiences and educate people [students and learners] on it [Indigenous health, racism in health care, etc.] rather than forcing [Indigenous] people who don't want to. – NS3

The value of having Indigenous voices in the classroom cannot be understated. Nursing students conveyed repeatedly that an Indigenous facilitator and voice to learning Indigenous health was important. However, students also pointed to the issue of representation – to the need to hear multiple Indigenous voices and for the university/college to make this a priority. They also cautioned against putting Indigenous students on the spot to validate or speak on Indigenous matters.

Students and faculty carefully considered the pros and cons of self-identifying as Indigenous. Cons of self-identification include being a spokesperson, being voluntold to confirm or validate Indigenous health content taught, being centered as the ‘expert’ on all things Indigenous and being further stigmatized or othered in the classroom setting.
2.2 Faculty’s preparedness and knowledge to teach Indigenous health

Faculty’s preparedness and knowledge base to teach Indigenous health also varied based on some students’ accounts. A few nursing students described learning from faculty with varying knowledge and preparedness in Indigenous health content which impacted their ability to gain insightful understanding. When asked about their learning experiences, students focused solely on faculty who identified as white settlers, as most had white faculty in their educational experience. The excerpts below are from nursing students who identified as a white settler and Indigenous, respectively,

I think a lot of that comes back to having white profs talk about Indigenous health. You know, it’s uh, “well, they have these problems” and, and, “they used to this”, or “they live in remote urban - in like rural remote community so they can’t access health care very well” and it’s like … okay, you know what I mean? There is nobody [white faculty] speaking from their personal experience. There is no discussion, like, I just don’t know, like I’m a white person, I wouldn’t teach a lecture on African culture, it just doesn’t make sense. I’m [white faculty are] going to create blanket statements. I’m [white faculty are] going to make inaccurate statements. I’m [white faculty are] going to be potentially racist because I [they] don’t know everything about African cultures and [south Africa], but that’s a different story. But like, you know know what I mean, it just doesn’t make sense. – NS2

I’m Metis and if I’m the patient I don’t need somebody to come into the room with a Métis sash and a fiddle, that’s not going to make me feel safe. That’s not going to make me feel better. I need the nurse to come into the room and still give me dignity, respect, and be competent and be safe, and you know…[…] Like when you’re not having somebody Indigenous teach Indigenous health or teach like how to interact with Indigenous patients then I feel like it’s just missing the mark because that’s what I’ve noticed in a few of my classes. - NS6

In the two students’ experiences, non-indigenous faculty may inadvertently contribute to making harmful blanket statements and stereotypes about Indigenous Peoples by ‘othering’ Indigenous Peoples in attempt to teach about Indigenous health. The lack of Indigenous representation presents a risk of unintended harm and misinformation being taught. The second quote from an Indigenous student conveyed how white faculty may teach on assumed Indigenous
cultural practices or conflate cultural practices with ‘Indigenous Peoples’ health. The second student also makes a point that there needs to be a shift to focusing on good relational practice rather than a focus on ‘culture’ when faculty teach on Indigenous health. Both students have also tended to essentialize whiteness in the context of Indigenous health which may be rationalized by the pervasiveness of whiteness in nursing and most faculty being white.

On the other hand, a nursing faculty spoke to the invaluable benefits of having white settlers teach Indigenous health, despite the problematic perception from the few nursing students. For example, an Indigenous faculty speaks to this in the following,

She's [White colleague who teaches Indigenous health] speaking as a more of an expert on whiteness, and the challenges of whiteness, and how whiteness has a direct impact on the social determinants of health for [Indigenous] people. She speaks from that orientation, and she models what it looks like to deal with the difficulties of conversations/interactions. Modeling how to acknowledge that you don't know and [what it means] to bump up against your own limitations and graceful ways to respond rather than enacting white fragility. I appreciate that the white settler woman that I worked with, had, has capacity, humility, and transparency, and she's very authentic. - NF3

The Indigenous nursing faculty further highlighted the authenticity and transparency skills of their white colleague which echoed some of the nursing students’ sentiments regarding self-positioning. Few nursing faculty also emphasized that there were variances in faculty preparedness and knowledge. An Indigenous faculty speaks to this in the following,

Whether that's an Indigenous instructor or a non-Indigenous instructor, whoever's instructing this material must be very well prepared with the theory and content and foundations of in, you know, Indigenous issues, colonization, and anti-racism. And if, if you're [faculty are] not, then students leave the class with, like, half-baked information. - NF2
In a similar vein, another faculty speaks to the need for faculty development,

So the community college wants to do a course - it’s now like a big pendulum swing and they started to, um, integrate things well in each course and we're still playing with really I think the missing part is more faculty development than it is student… because you know, students are still telling me things like, you know, instructors are telling me things like there’s an Indigenous student in room 601, take that person for today and go and learn with them so you can learn about [Indigenous Peoples/health] - and it’s like no, no, but you can see that, but you can see, but um they're not like making assumptions - so you can say that everybody’s eager to do it, they just need a little guidance on how to do it. – NF1

Here an Indigenous faculty highlight the momentum of learning about Indigenous health, however, there is a need and ongoing challenge of increasing faculty development to teaching Indigenous health. Faculty’s whiteness was seen as a challenge by a few of the nursing students to their learning of Indigenous health. They noted that inauthenticity, proneness to othering, and a lack of knowledge contributed to the challenges of learning Indigenous health. However, on the other hand, teaching from a clear position of whiteness could be a facilitator to teaching and learning about Indigenous health by way of self-positioning, relational engagement, and critical reflection.

2.3 Faculty’s racial identity development

Nursing faculty spoke to their own racial identity development from their own positionality and to how they perceived nursing students’ development through their interactions with students in the course(s) they taught. They observed that nursing students move from historical positioning into relational positioning and self-positioning. Few nursing faculty cite that they are witnessing nursing students entering nursing programs with historical positioning, that is, an awareness of the histories of colonization. A nursing faculty delicately describes their experience of teaching Indigenous health in the following,

It's sort of evolved into more of a, you know, examining your own relationship with yourself, your positioning, with Indigenous Peoples, you know, self-examination, the
aspect of relational practice, building relationships, and positionality…that has made the experience for the students much more multi-dimensional. And, you know, I wouldn't say good necessarily, like I've had lots of pushback from students and negative course experience, survey results, name calling, you know, like, all those sorts of negative things, but I've also had some really transformational experiences and, you know, positive feedback from students about their own insight. So, you know, the journey for teaching this stuff [Indigenous health] has been, you know, all over the map. And now, because we have a much more educated cohort of students coming into nursing schools, and educated in terms of colonization, the work that I have to do to get people kind of onto the same page with just sort of historical knowledge is much less. And now we're sort of focusing on the relationship they have with themselves and their own [white] privilege. Whereas before, it was all about, you know, the [historical] facts. So, that's, that's really shifted. - NF2

The shift from historical positioning to self-positioning and further to relational positioning has been echoed by other nursing faculty. Inclusion of current societal affairs have been cited as a facilitator to learning Indigenous health in that anti-racism can be connected to real life events and narrow the distancing that can come with the discomfort of learning about one’s own privileges and biases. Few nursing students have stated that societal events, such as Black Lives Matter movement, findings of unmarked graves across Canadian Residential Schools, among others, have helped them understand intersectionality of race, gender, and class, among other determinants.

Indigenous and non-Indigenous faculty who also go through their own racial identity development can meet the learners where they are at in their learning to move beyond the historical positioning. For example, a nursing faculty speaks to their own racial identity development in the following,

I think like anything, my, the trajectory of my teaching has grown over the last 15 years. And it's sort of mirrored my own internal growth and courage. Being a member of an oppressed group or marginalized group, I sort of grew up in nursing, being taught to toe the line and anytime I stepped outside of that, I would be disciplined or punished or sanctioned, or censored, or, you know, silenced by my nursing peers. And so moving into by my non Indigenous nursing peers, I should specify. And so learning to step outside of that professional coercion, and hav[ing] some kind of trust in my own voice, was a journey that kind of came alongside with the teaching. - NF2
Nursing faculty are on the learning journey alongside their students and go through feedback processes and self-reflection on their own ways of knowing, being, and teaching over time. A nursing faculty speaks to this in the following,

You know… as the person providing the teachings in class or being the lead of the conversation, it impacts your health and wellness as well. No question because you're, you feel the responsibility for the dynamics that are going on. The truth is Indigenous specific racism is active in the class, you know, that's going on all around you all the time. In that space, it’s not so different than other spaces. So holding that responsibility seriously, and holding it also lightly, and celebrating the opportunity to do the work. – NF3

Nursing faculty who identify as Indigenous face additional challenges such as risk of harm throughout the process of teaching Indigenous health by way of being in-tune to the emotional responses and vicariously absorbing all that is occurring in their classrooms. Faculty need to navigate the students’ responses and at the same time, have responsibility for the classroom dynamics. This highlights the need for faculty preparedness to take on the emotional labor anticipated to lead or facilitate Indigenous health courses or content in nursing education.

Theme 3: Decentering Whiteness in the Classroom

Decentering whiteness in the classroom was a prominent theme across faculty who speak to the balance and the role they play throughout the learning journey. Subthemes included 1) white fragility in the classroom, 2) challenges in positioning one-self, and 3) cultural safety in the classroom.

3.1 White Fragility in the Classroom

A few nursing students and faculty also spoke to the ways in which Indigenous health content reflects a bias toward pathologizing and victimizing Indigenous persons and negative notions from the colonial effects and long held stereotypes being taught. Students grappled with the tensions that arose from the content learned and were limited by their fear of saying or asking
the wrong questions in class. This was often coupled with feelings of guilt and shame related to the harsh realities of colonization and their connection to it. A student speaks to this in the following,

I would think one [challenge] would be kind of just like, not wanting to ask questions or like, because, there's a lot of a lot of tension when the topics are discussed. [...] Like, I think Indigenous like sovereignty [...] Or like self-governance [...] is like a big thing that a lot of people don't understand. [...] I'm very kind of like nervous to ask like, so I don't really understand like, because I don't have the same experiences, I don't understand, like, why that's what you [Indigenous Peoples] want. And like, how we [white settlers] could do that, and how it would make things better and how it would work. [...] But it's just like, I don't want to ask those questions, because it's very, there's like a lot of nerves about being like seen as ignorant. – NS3

The nursing student identified tensions around the perception of her peers judging her for her own learning gaps, and thus remained silent to not seem ignorant. White fragility in the classroom can arise when emotions of settlers arise due to the guilt and discomfort of learning. This discomfort and the resultant inaction or silence may inadvertently stagnate student’s ability to grow and learn about Indigenous health. Acknowledgement and navigating the conversation is a needed skill by faculty to decenter white students’ tears.

An Indigenous faculty speaks to the feelings of discomfort and guilt witnessed in students and suggested changes in nursing curriculum that would help to counter white fragility in the following,

Nursing curriculum would benefit from “having classes on whiteness, colonialism and settlerism that are facilitated by non-Indigenous people and co-designed, implemented and facilitated by Indigenous peoples and people of colour.” A distinction between the white settler colonialism and Indigenous health and wellness curriculums would place the responsibility for managing white-settler fragility with white settlers. This distinction would create more opportunity to center Indigenous health and wellness within Indigenous health and wellness curriculum. - NF3

Here the faculty speaks to the white fragility that can often occur in the classroom and that changes such as teaching on privileges that come with whiteness can de-center whiteness.
The faculty also highlights the importance of Indigenous-driven curriculum in this domain. They also stated that, white tears should be acknowledged but moderated so that learning may progress for the class. White tears can show up when students who benefit from white supremacy deal with extreme emotional guilt, shame, and intentionally or unintentionally need their emotions to be tended to. The notion of white tears centers settlers’ emotions and delays or distances learning about the uncomfortable truths of colonization and its impacts on Indigenous peoples today.

3.2 Challenges in Positioning Self

Few nursing students focused on a perceived negative impact of white faculty teaching Indigenous health. A student states that faculty’s self-positioning is an important aspect to incorporate if and when a non-Indigenous faculty teaches Indigenous health content as in the following,

So we [students and faculty] all have our own experience of it [racism and witnessing racism]. And like, I have my own experience of like, racism against Indigenous people that I’ve seen. But I obviously don’t experience it the same way [that Indigenous Peoples do]. So if I'm talking about it [racism], […] I like to make note that it's like, I've seen stuff like this, but I don't actually understand from the same way because obviously, I'm not Indigenous. Just I think it's really important to like, acknowledge that you're coming at it from a different perspective and giving a little backstory of like, what their [the professor or faculty’s] experience was, and like, why they have their beliefs and views and stuff [understandings], rather than it coming across as just, oh, this is just curriculum you have to learn. - NS3

Self-positioning or self-location of professors and faculty from students’ point of view can create grounds for nuanced understanding as opposed to ‘these are blanket statements that have to be taught about Indigenous health’ from a student’s perspective. Part of faculty preparedness from few of the students’ perception is knowing how to self-position or locating one-self in relation the content they are teaching. Challenges with self-positioning by non-Indigenous faculty can be perceived as detached and inauthentic, thus prevent building trust
between faculty and students in the learning environment. This contributes to feelings of safety in the classroom.

3.3 – Cultural Safety in the Classroom

Nursing faculty adds on about safe learning spaces, for example, as follows,

As Faculty, you see students' apprehension, sadness, fear, withdrawal, and anger responses. The reality of structural and interpersonal racism is a part of the classroom experience and influences class dynamics. These dynamics require negotiating every day and structural racism and white power and privilege in the classroom. The shifts in power dynamics from a society that privileges whiteness and settlerism to a classroom that centres Indigeneity inevitably surfaces white fragility and white tears. White students can interpret this shift as being white victimization. They can see themselves as harmed in these conversations and can act to maintain or reclaim white power dynamics by enacting white fragility or white tears. These power dynamics require restraining to contain the harm and re-focusing the discussions on Indigenous health and wellness. Supporting students who enact these power dynamics requires an approach that holds them well mentally, spiritually, and emotionally and challenges them to understand/feel the power dynamics that are occurring. It is about increasing their intellectual and emotional racial literacy. – NF3

Here an Indigenous nursing faculty member is speaking to how they create a safe space for all learners, and as a faculty, being ready to acknowledge and moderate “white tears” in the classroom, to help move the dialogue along for the rest of the class. Faculty have highlighted that white tears and white fragility are expected within Indigenous health education so navigating that is part of creating a safe space for all learners. The art of moderating white tears is not to dismiss, but to acknowledge and facilitate the conversation forward while building emotional and intellectual capacity and resilience. Nursing faculty saw this as a true balancing act; to not lose students in the learning process. Culturally safe space for learning and inquiry were recognized as an essential aspect of learning about Indigenous health from nursing students and faculty alike. Both the faculty and student participants identified tensions, emotional discomforts, and
facilitators that can promote a safe and effective learning journey for nursing students which will be elaborated on in the next theme.

**Theme 4: Creating Cultural Safety in the Classroom**

Readying the classroom, class size, time for critical reflection, and instructor’s classroom set up were identified as factors by students and faculty that can enable or pose a challenge to building rapport and trust between nursing students and faculty/professors.

4.1 Readying the Classroom

When asked about ways how safe learning spaces might be provided to facilitate learning, a nursing student spoke about the following,

> I feel like it would definitely help if [instructors] like preface it with like ‘this in a safe place.’ And, like, facilitated more as a discussion because I feel like a lot of the information we received on Indigenous health is a lot of like, being told, like, what's going on and what, and then like, not having really opportunities to ask questions or having opportunities after [class]. – NS3

The nursing student highlights the need for open discussions and having a safe space to be curious in a non-judgmental way to promote learning. The learning journey can provoke emotions that need to be acknowledged or moderated. Setting the stage for learning was echoed by faculty in their example of co-creating learning contracts at the beginning of the Indigenous health course with their students. This fosters and space built on mutually agreed upon terms of learning and participation and creates a sense of safety.

4.2 Class Size

Class size can impact the way Indigenous health is taught and taken up. As one student notes, “I feel like it should be more of like a discussion - not a let's sit and listen to our [faculty] talk about the social determinants of health, you know, that's hard to do. That’s 125 kids.” – NS3
Being in a large classroom can present challenges to breakout sessions or intimate discussion groups for students. In the example above where the student expresses that her class of 125 students is more likely to have a didactic approach to learning as there is only one faculty who can facilitate the learning. It was conveyed on multiple occasions that smaller class sizes would enable more interactive dialogue during the learning process. However, this would also be dependent on a faculty’s preparedness to facilitate in-class discussion.

4.3 Time for Critical Reflection

Time for critical reflection was considered a strong facilitator in learning of Indigenous health. A faculty speaks to this in the following,

Giving time for processing, right, this is if we really want uptake of this information, it’s really critical to be conscious of the amount of input that you’re giving a student and the amount of time you’re allowed to process it. And so I mean, and that’s just a really sort of basic pedagogical principle, but I find in nursing school, or in any sort of academic setting, sometimes, profs can overload students with reading, thinking everything is so critical to understand. – NF2

The nursing faculty found that in courses that are inundated with content and preparatory reading may not be helpful in sustaining learning or enabling reflection. In a course taught by an Indigenous faculty, students had some preparatory work, but content was generally generated through in-class circle discussions and aimed at prompting critical reflection. The basis of the content generated is personal, reflective, and garners students to be fully present and engaged. On the other hand, in courses where lecture style was the main mode of learning Indigenous health, students sometimes are left to question and reflect on their own.
A few nursing students consistently preferred interactive dialogue that can promote reflection to that of passive didactic lecture style learning. An Indigenous nursing faculty speaks to the strengths of an ‘Indigenous-led’ pedagogies in the following,

Part of it is I think engaging with the self and knowledge of self and understanding like holistic and holistic practices and measures and getting to really understand like what what are four directions? How do you self [reflect] - what is it to be self-reflective of, you know, spiritual, psychological, - we start to look at all of these things I think they [the students] actually liked it. I think it speaks to them [the students] more than in some way but the second [part] is because it's circling [an Indigenous pedagogy, ] and they have been taught it's very slow and they have a lot of time to think and they’re not being crammed with content, and they're learning how to be respectful and listen to others’ ideas and so we really go into a lot of that [in the classroom]. They seem to really appreciate that compared to all the other courses which seemed to be so content driven so heavy with, you know. - NF1

Use of critical self-reflection and a circle pedagogy were seen as key components to teaching Indigenous health – this is one of the ways to combat the challenges related to time, didactic learning forums and a lack of relational engagement.

Other methods of teaching can include case studies. In one school of nursing the use of case studies was unilaterally erased from the curriculum as it was seen to be potentially harmful to perpetuating stereotypes. An Indigenous nursing faculty speaks to this in the following,

There was this erasure [of Indigenous health content] – you can no longer do that. I had a difficulty with that but I’m just - I’m retrying it [case studies] and it seems to be going well - because if we erase it, then you never have a chance to have a conversation with the students and they might never have a chance for reflection or to sit and hear themselves. – NF1

The nursing faculty identified with bearing witness to nursing student’s critical thinking development through critical reflection exercises and the incorporation of opportunities for dialogue that can provoke further reflection. This is important for learners dealing with uncomfortable emotions and personal growth in this domain of practice.
4.4 Online Learning

COVID-19 pandemic created additional challenges to learning related to online learning. A nursing student describes their experience in the following,

Most of my classes have been like online and they’ve been pre-recorded lectures and PowerPoint so there’s been probably little to no interaction. […] I feel like just when I think COVID is going away in a way, it comes back again, so I try not to hold my breathe. – NS6

‘Pass/fail’ courses, asynchronous passive learning, and limited in-person interactions to apply learning were seen as challenges to student learning. Although this was identified in light of the COVID-19 pandemic, the increased use of online learning remains relevant. Here the student describes the lack of relational engagement with their peers and faculty and the difficulty in embracing deeper learning beyond the histories of colonization. Nursing faculty also elaborated on their experiences of teaching with the shift to online learning and the challenges that occurred. As one faculty notes in the following,

During COVID, we moved online and held classes on Zoom, which impacted how the course delivery and how the content would be experienced. Cultural Safety prioritizes relational practice, which means building strong and meaningful relationships. Indigenous health and wellness use a decolonized approach to course delivery. Most of the work is done in Circle, and there is a focus on teaching and modelling relational practice. While we tried to use a circle process online, and the students leaned into this effort, technology limited its success. Some students did not have cameras, and some did not have microphones. Those without microphones typed their comments into the chat, and I read them out for the class. The online experience limited the course effectiveness and, as such, student learning. Online learning opportunities can be helpful for the early stages of unlearning/learning about Indigenous-specific racism and white power and privilege, as they can restrain reactive responses such as white fragility and white tears. And the embodied somatic, emotional, and spiritual components of in-person learning embedded in the Circle process and relational practice are foundational to student learning – NF3
The nursing faculty’s sentiments echoed students’ learning experiences during the COVID-19 pandemic. Learning in-person as opposed to online was seen as a facilitator. Sharing space in-person can enable embodied learning experiences and promote relational engagement for students and faculty. Again, this is essential to building trust where students and faculty can learn from one another and hold space for one another’s ways of learning and processing content generated together.

4.5 Choice and evaluation of learning

A few of the nursing students commented on their thoughts on having choice in how they learn and the value of evaluation of learning Indigenous health.

I don’t even know how you would measure the success of teaching students about [cultural competency, cultural safety] because, of course, we have exams and anyone can memorize what cultural safety is. Um… but do we practice it in the clinical setting and how is that measured? I have no idea. – NS2

This nursing student notes that memorizing concepts is not an effective method of evaluating learning. In a similar vein, a student speaks to classroom learning and evaluation and applied learning in the following,

I don't know if it'll help necessarily, to make it like a forced activity; to be like, “oh, you have to participate in this Indigenous experience to like, get a grade or whatever. But [instead] to make like more opportunities to do that, and like, or make it [so] [students] kind of have a choice of multiple things to do, like, you can watch a documentary or attend a sweat or attend a powwow and kind of like given people the opportunity to do the different things because everybody learns differently, and everybody feels comfortable in their own way. So I think, just having like the best presented [options] if people have like, options of how they [want to] learn about it [Indigenous health]. – NS3

Here the nursing student points to the perceived forced learning and importance of choice (acknowledgement of different learning styles and comfort) and considerations of various forums
(pedagogies) for learning, including experiential learning. Different approaches outside of the western didactic method to learning may have its own challenges to the way it can be assessed or evaluated for effectiveness.

Another student mentions their thoughts regarding the grading system of learning Indigenous health.

when it’s like a discussion group that you post that you’re doing for marks, then as long as you give a decent response you’re going to get decent marks. I think taking away – and I have been thinking about this a lot lately – taking away like the graded component of it and just having it be a learning experience would be efficient in a lot of ways. I understand they have to put a number to things at the end of the day but I think it just puts pressure on it and makes it feel like work instead of something you actually want to do. Yeah, I was reading about how – a study came up while I was researching something different about how subjective and unreliable grading systems for nursing students are anyways, [laughs] then why are we doing any of this? Why isn’t it just pass/fail for everything? – NS5

The idea of learning for the participation mark was bewildering from this student’s perspective. Learning Indigenous health was seen as an ethical journey that should be embarked on without the fear or pressure of a grading component.

Evaluation of learning was at the discretion of the faculty member teaching Indigenous health content or course. Nursing faculty work to find the balance between integrated student learning and the provision of different learning modalities and the need to provide a course grade. One faculty speaks to this challenge in the following,

I’ve been doing it this particular course for four years and I think there was only one group that really, they really just – I mean it was just resistance and unfortunately sometimes things just don’t work out so of course I’ll let people do art work or whatever I’ve had that people can give me whatever as long as they answer to the assignment. Well, when this group came along – because they didn’t do all this other work, they weren’t able to answer the question so they got a bad mark right? So that motivated them. So I don’t know – that’s the only group I can think of – did they really see the light on the –[laughs] I don’t know but they did realize that they didn’t do that particular thing their
mark was going to suffer. Not because I could be punitive they just didn’t have the content because they never talked in the circle. They had to be able to, right? So it’s sort of a blend. What the students seem to tell me they like is – it’s not a lot of prep work. They like having time – so it’s a three hour seminar so it goes fairly long. There’s breaks in between. But they get time to sit. They sit on the floors – sometimes we go outside [...] and they sit and talk and listen to each other. And that is the big shift that’s really what it is. And they like the content because it’s talking about things that are going on in the world. [...] And they seem to really really like this opportunity. Whereas and it’s a little different than – because they have to circle and there’s questions to consider but they don’t have to come up with the answer. They just have to talk about it. The answer comes. I know it’s going to come. It’s different if I was running another group that said “meet with your group you have 20 minutes – answer the question.” Everyone would talk but they’ll just choose the best ones. Strongest voice will say this is what I think we should do. The one that doesn’t give a crap will say I like your idea and they move on, right? – NF1

Here the nursing faculty speaks to their experience of having a class/cohort that was disengaged and did not contribute to circle sharing in the course. Nursing students can have different learning styles that may warrant further assessment on modalities to incorporate, or may be completely averse to certain Indigenous-led pedagogies. This can be challenging for faculty to evaluate learning and sustainability of learning. On the other hand, asynchronous or didactic learning forums, where engagement in content is passive or absent, can also be a challenge to evaluate learning and the sustainability of what has been learned.

Evaluation was taken up in various ways by nursing students and nursing faculty. Nursing students interviewed wanted options for learning Indigenous health and felt that evaluation forces memorization of content rather than engagement. Faculty need to incorporate some kind of evaluation, however, their major aim was to ensure students were contributing to the creation of content through relational engagement and critical reflection to support the integration of content and sustained learning.
Theme 5: From Classroom to Practice

Subthemes in this theme included 1) facing backlash in practice, 2) sustainability of learning, and 3) structural changes.

5.1 Facing Backlash in Practice

After discussing the experiences above, nursing students further elaborated on how it was particularly hard for them to address these acts of racism in education and in clinical settings. A nursing student speaks to this in the following,

You want to speak up and you want to say something but not really feeling like you can. And feeling like – otherwise she was a really great nurse, but we’re still having these perceptions and what can you say in clinical practice that’s not going to like jeopardize you and as a student in general – jeopardize your learning. - NS5

Students often find it difficult to speak up due to student-instructor power dynamics and the worry about the backlash. This nursing student feared that speaking up might hinder their clinical progression if the nurse they report on gets into trouble.

Another student reflects on this issue in the following,

I made an anonymous complaint like through my Indigenous Students’ Union. To my knowledge it was kept anonymous. But somebody else also made a complaint [about the instructor who [misspoke] … and then when I was in clinical, she wasn’t my instructor but she came to assist with medications day and she gave me a really hard time. She downright bullied me. I was like is this just a coincidence or is this because somehow she heard I’m the one that said, that made a complaint – like that’s going through my head. - NS6

Nursing students grapple with speaking up and addressing manifestations of racism in nursing education; a fear of retaliation and hindered academic progression were strongly espoused by few of the nursing students. The nursing students interviewed questioned the applicability of learning Indigenous health and found that there is a gap in the care provided, the way instructors and clinical mentors continue to racialize Indigenous peoples, and the way their
academic progression would be at risk if they speak up about acts of racism in the classroom and clinical practice.

5.2 Sustainability of Learning

Sustainability of learning Indigenous health was called into question by a nursing student, “I don’t know how [evaluating] gets done. And I would say that when you still have nurses at the hospital treating, you know, being racist, towards patients then well, maybe it’s not coming across that well.”– NS2

Here a nursing student questions whether their learning, the evaluation of learning has a sustainable impact in the practice setting.

In a nursing faculty’s experiences, experiential learning at local reserves or Indigenous health organizations were espoused as invaluable to students’ learning journey and could be a way of sustaining learning and relationship with local communities. However, thorough preparation is required in order to prevent students from inadvertently harming the local Indigenous communities. A nursing faculty identified that preparation included the classroom work through circle pedagogy (as an example), interviewing students who were interested to assess readiness, orientation work and the creation of safe spaces for debriefs and critical reflection (praxis) during the experiential learning placements. The nursing faculty emphasized that the experiential learning was not a “zoo” experience where students go into community to simply observe and take without giving something back and being respectful as a visitor. As such, they maintained that the focus needed to be placed on building respectful collaboration with local Indigenous community members and having rapport and trust as a basis of all health-related work. A nursing faculty conveyed that the relationships fostered through the placements highlight the necessity of respectful collaboration to drive transformative learning.
5.3 Structural Changes

A nursing student describes her university and its relations to Indigenous Peoples when asked about how the institution or university’s stance on Indigenous matters impacts their learning,

[One of the Indigenous professor] was part of a mass exodus of Indigenous professors that left the university because they didn’t feel like they were being listened to and respected. Feel like it’s – and you know […]– it’s tough to see that the institution has a positive relationship with Indigenous Peoples because if they did, you wouldn’t be having those problems. So I think that’s always in the back of my mind when I get classes on Indigenous issues, it’s like what part of this is real and comes from a genuine desire to improve relations and improve health and what part of this is performative and ‘because it’s the popular thing to do’ – because it looks good on paper, because it’s you know, required by legislation, like I don’t know. I um I’m kind of just – I’m skeptical of it. Every time it comes up, which is why I’m impressed with how the individual instructors do. Because I feel like they actually individually really care and you can see that whereas when it’s coming from this faceless institution – it’s kind of hard to see. I don’t know – like it’s not perfect and I’m glad that I’m able to see the flaws and not just take it at face value. – NS5

Relationship with local Indigenous Peoples were seen as a crucial factor by students. The student goes onto highlighting that Indigenous professors are leaving due to underlying issues of lack of relationship and the challenges placed on them when they are not respected for their Indigenous knowledge or as a person. In essence, the student demands a need to go beyond performing or tokenizing Indigenous matters or persons and integrate accountability mechanisms on a systemic level.

A faculty adds on to the need for structural change by having reporting mechanisms on acts of racism. The faculty states they could see a shift occur with students learning throughout the course and their application in the real world.

So as a result of our work too we now have incident reports that came out after the first year the students kept talking about um well, they talk about incivility or horizontal
violence but they start to talk about racism or systemic racism so we did a presentation – myself and another colleague to the [health organization] to say ‘have we considered racism as a critical incident?’ It does harm, so if somebody sticks themselves with a needle or a patient – you know what I mean? So we use quality assurance and all these tools to really look at these other things and critical incidents and there’s debriefing and that – so we want to put racism on that and that’s going along. And there’s multiple people, not just us now. There’s a whole anti-racist coalition and there’s groups going on at [health organization] so we try to get the students involved in that and I find that, that would be a shift. In the course they become more engaged with these kinds of movements or things on campus because they seem more informed. But really, just to feel safe to call out like these kind of – even the microaggression ones.- NF1

Here the faculty comment on witnessing students desire to advocate for change and the need for critical incident reporting systems in educational and clinical settings. Taking learning beyond classroom learning and implementing accountability mechanisms as a normal practice like that of quality assurance can create a safe environment for students and nurses to report incidents of racism.

The faculty states the explicit orientation to such incident reporting mechanisms is necessary.

It states very clearly of course that it won’t be used punitively – you won’t be veiled because you ruffled somebody’s feather. And what – we literally have to say those words so when you orientate the students at the beginning – that’s what we say. ‘if this happens, you will not fail because of this’. ‘You will not have a mark on your name.’ ‘You will not be pun[ished]-‘ because we’re trying to create a safer spaces and so having a student advisor that a student can go to.” – NF1

This explicitness in orientation will lay the foundation for students to be aware and have a sense of backing if they have any concerns throughout the education and clinical experiences.

Another nursing student commented on the changes needed at the systemic level when speaking about their university’s stance on addressing Indigenous health matters,
I think honestly that [university] has made an effort [with reconciliation]. Um, I just think that like when you have people who are not representative of the populations that they are serving making decisions about those populations, you’ll never sort of have any justice. Like you’ll never have, you know, proper. If you have, if you have improper representation, how can you have proper implementation of you know, [policies], programs, programming. – NS2

Here the student suggests that representation is paramount in the leadership levels and places where decisions are being made about supporting Indigenous leaders, faculty, and students.

Furthermore, Indigenous nursing faculty highlighted that people of color should be taking up the space and included in educating nursing students as to further diversify ways of knowing and enact anti-racism stance in the institution. In a slightly different vein, another faculty speaks to education reform and how anti-Indigenous racism might be incorporated in the following,

It's a process, a deliberate and intentional process that starts from the moment [student] nurses are greeted into their [educational] programs, maybe even before that in their application processes. So that there's an awareness about where people [themselves] are in this journey. And then when they're greeted [into the nursing program], and starting their learning journey, like it's a thread a consistent thread that goes from accepting people into the program all the way to completing the program, and that there's a connection to the workspaces that they may find themselves in. It is also important to ensure that relationships are build with Indigenous peoples and communities whose lands they are living on and with whom they may work and/or provide services too. I think it's a real process. - NF3

Here the nursing faculty emphasizes indigenization as a “deliberate process” that calls for respectful collaboration and meaningful relationships to build supportive infrastructures that go well beyond recruitment of students and faculty who identify as Indigenous. The nursing faculty elaborated on how this process must be led and refined by incorporating feedback informed by local Indigenous communities. Collaborative partnerships are essential for building rapport and trust between colonial structures such as the university, the health care settings, and the local community.
Chapter Five: Discussion and Implications

In this study, we aimed to explore nursing students’ experiences of learning Indigenous health across Canada by using postcolonial theory to inform our work. Postcolonial theory draws our attention to examine themes relating to the issues of race, racism, power imbalances in relation to socioeconomic, historical, cultural contexts of health and healthcare (Anderson, 2002; Reimer-Kirkham et al., 2007). Postcolonial theory provides a lens to which we can critically analyze our findings from a colonial perspective and its current manifestations in nursing education, clinical practice, and the wellbeing of Indigenous peoples (Browne et al., 2005). The study’s research question and sub research questions centered around current approaches, facilitators, and challenges of learning Indigenous health content in Canadian nursing schools. Using a thematic analysis informed by critical ethnography and post-colonial theory, we elicited five overarching themes: *Encountering racism in education and practice, need for faculty development, decentering whiteness in the classroom, creating cultural safety in the classroom, and from classroom to practice*. The themes are illustrated in a cyclic cycle (Appendix B) with accompanying subthemes, demonstrating students’ experiences of learning Indigenous health from the classroom into practice. Each theme will be elaborated on in the next section.

**Encountering Racism in Education and Practice**

Encountering racism in education and practice was common among nursing students within this study and was a main motivator for study informants to participate. Racism in overt and covert ways included narratives that stereotyped Indigenous or racialized students, persons, and/or patients. In the classroom, proneness to othering Indigenous peoples reaffirmed white heteronormativity and supremacy. The standard of whiteness has lent ways for non-Indigenous faculty and students alike to distance themselves (Tuck & Yang, 2012) from the inequities
brought on by colonization on Indigenous peoples and communities, thus sustaining the hegemony of the institution. This is consistent with Martin’s (2006) critical ethnographic study on Aboriginal students’ experiences in two Canadian nursing schools. In practice, students witnessed and became bystanders to healthcare worker’s microaggressions and racism toward Indigenous and racialized patients. Part of the bystander phenomenon can be attributed to the power dynamics at play between students and nurse-mentors or educator whereby the student remains at risk of repercussion for speaking up. However, the pervasiveness of racial incidents named here also exposes the larger socio-political, colonial legacy of segregation and purposeful ignorance. Roy-Michaeli (2011), Francis-Cracknell, et al. (2019) and Sylvestre et al., (2019) discuss how harmful stereotypes are further entrenched when settler educators are unable to make critical connections for students. Furthermore, our study findings are consistent with Sylvestre et al. (2019) implication that we must engage in ongoing processes of unlearning myths and stereotypes perpetuated in the euro-western education system, media, and institutions.

Roy-Michaeli’s (2011) study contends that essentialism and culturalism are problematic long-held beliefs in Canadian nursing as it can promote stereotyping. For example, study participants recalled their encounter with a nurse-mentor who assumed that a patient had alcohol addictions and went to check if that patient’s last name could be identified as Indigenous. This nurse’s culturalist view of the patient equated them to a harmful stereotype that demeans and negatively alters care. Postcolonial theory helps us make the linkage from the past socio-political treatment of Indigenous peoples to the present-day discourses that continue to be perpetuated (Browne, Smye, & Varcoe, 2005). Edward Said’s literature on ‘Orientalism’ as a central tenant of postcolonial theory raises awareness and rejects the essentializing nature of colonization whereby the ‘colonizer’ prescribes and upholds ideologies of the inferior ‘colonized’. This theme
aligns with consciousness raising and rejecting essentializing, as students encountering and witnessing interpersonal racism is linked to their increased awareness of inequities brought on by deeply rooted colonial racial discrimination in healthcare interactions. Students in this study were motivated to participate to raise further awareness and bring about change.

Furthermore, our study’s findings show that current approaches to teaching and learning about Indigenous health include teaching concepts such as culture, cultural awareness, cultural sensitivity, and cultural safety across multiple nursing courses. These concepts can sometimes be conflated with specific ‘cultural practices’ in the clinical context. For example, teachings to students may include the practice of asking Indigenous patients if they would like to smudge or have specific cultural practices they would like to include in their care. Although cultural practices can be respected and included, caution must be taken to not assume Indigenous persons are homogenous and rely on the same practice(s) to promote and meet their health goals. This aligns with Homi Bhaba’s (1994) addition to postcolonial thought of the concept of “third space” or “third culture” whereby individuals who interact within this space should adjust one’s own sense of their socio-cultural identity to explore new ways of building relationships with another, to move beyond the dichotomy and tension of colonizer versus colonized. This finding is also consistent with Tujague and Ryan (2021)’s conclusion that teaching cultural safety in the context of Indigenous health is more than a tick-box on compliance in theory and practice. It also aligns with Downing and Kowal’s (2010) ‘objectification paradox’ whereby teachings about Indigenous culture have some merits; however, should not only be about cultural awareness raising, as it is more about understanding how one’s own understanding of culture contributes to creating cultural identities that can perpetuate colonial discourses and maintain power imbalances.
Need For Faculty Development

Students have expressed discontent with the lack of Indigenous representation in the classroom environment and made linkages to the inherent lack of representation at the leadership levels where decisions can have drastic impacts in the way they support or do not support Indigenous faculty. We found that students deemed Indigenous voices and representation to be a major facilitator in learning Indigenous health. Despite good intentions, some students found current non-Indigenous faculty who are mostly white settlers have caused unintentional harms, which would warrant the need for faculty development. Faculty development is not limited to understanding the historical context, faculty’s own positioning/self-location, learning to facilitate critical discussions within the classroom and being ready to be co-learners in Indigenous health. This is consistent with Francis-Cracknell, Truong, & Adams’ (2023) findings on non-Indigenous educators in physiotherapy and occupational therapy programs in Australia, wherein the professional development is crucial and must incorporate tenants found in this theme.

An unexpected finding was that Indigenous nursing faculty, on the other hand, have alluded to the benefits of having non-Indigenous (white and settler) faculty teach Indigenous health such as teaching from a place or positionality of whiteness – where students can learn and unlearn the privileges, biases, and inherent power they hold in a white supremist society. This finding reflects the nuanced complexities laid out by a non-Indigenous settler educator on how their positionality can impact Indigenous health education positively by their ability to show up authentically and practice self-reflexivity in the conversations they have with their students (Hayes, 2021). A challenge noted was that non-Indigenous faculty outnumber Indigenous faculty and as such, must bear responsibility in teaching Indigenous health while making space for Indigenous representation. The colonial legacy of white settlers in nursing have resulted in
generations of euro-western epistemology in nursing education and thus privileges Eurocentric ways of knowing and acting in practice settings as well. White settler faculty can take away from this study that they are accountable to reconcile and decolonize nursing education by incorporating some of the following tenants as starting points to be an effective educator in Indigenous health.

Our findings demonstrate that faculty preparedness and comfort in teaching Indigenous health varied greatly despite good intentions to implement Indigenous health into nursing curriculum. This reflects previous study conclusions that faculty with limited knowledge and confidence related to Indigenous health can negatively impact the content and delivery of Indigenous health education (Vass & Adams, 2021; McIver, Murphy, Curran, & Parrish, 2022). The implications of this was reflected in participants’ frustrations on how some white faculty are “missing the mark”, particularly individuals who may lack the ability to self-position coupled by lack of knowledge and preparedness. These shortcomings need to be contextualized to how colonialism and the erasure of Indigenous peoples and histories have ongoing impacts and require active resistance, active learning and un-learning, and open-ness to unveil and question one’s ways of thinking about colonialism as a “thing of the past” to its present-day manifestations.

Few students in our study stressed the need for faculty development for mostly faculty who are non-Indigenous and identify as white settlers. However, faculty and professional development is applicable for all faculty whether they identify as non-Indigenous or Indigenous. That is because Indigenous faculty may be reclaiming their identities and/or new to teaching and learning Indigenous health. The research member acknowledges how the use of postcolonial theoretical concepts of the ‘colonizer’ and ‘colonized’ may unintentionally essentialize and other
whiteness or create a love-hate dichotomy of Indigenous and non-Indigenous (Burney, 2012). In this sense, our ethnographic interpretations acknowledges that the third space where Indigenous and non-Indigenous persons bring their knowledge, cultures, and experiences is a form of hybridity. This hybridity may lend way for potential to implement Two-Eyed seeing, which according to Mi’kmaw Elder Albert Marshall of the Eskasoni First Nation, refers to “learning to see from eye from the strengths of Indigenous knowledges and ways of knowing, and from the other eye the strengths of Western knowledges and ways of knowing, and to use both of these eyes together for the benefit of all.” (Jeffery, Kurtz, & Jones, 2021, p. 321).

It is worth noting that all three faculty informants in this study self-identified as Indigenous, even though student informants speak to their experiences of mostly learning Indigenous health from non-Indigenous or white settlers; there were no white settler faculty who came forward to volunteer to be in this study. Sylvestre et al.’s, (2019) study found that medical educators "lacked the critical tools to engage with questions of race and racialization and how these manifest in the context of [education and practice]” (p. 1). Our findings are consistent with this study and adds that the anti-racism needs to be confronted by individuals and the institution to allow critical dialogue in addressing anti-Indigenous racism. The lack of white settler faculty participants may also be attributed to faculty’s imposture syndrome, reluctance to speak on uncomfortable nature of self-critiquing personal or faculty teachings on cultural safety or antiracism, sense of confidence in teaching, or an overall sense that individually or institutionally, they are doing enough already in implementing Indigenous health within nursing curriculum. The lack of white settler faculty in this study may allude to the bystander effect of white privilege affording individuals or groups to stay neutral in circumstances of social justice intervention. Gayatri Spivak (1999) launched the concept of “sanctioned ignorance” which
denotes the purposeful reproduction and foreclosing of colonial structures and legacies. This term and concepts gives agency to the omissers who are choosing to remain ignorant or purposefully silencing of particular contexts as being irrelevant. Vass and Adams (2021) discuss the absence of anti-racism and reluctance for self-reflexivity [by educators] as barriers that impede learning and promotes non-Indigenous educators to choose to minimize content taught despite its significance to Indigenous health. On the other hand, one way to counteract this would be for non-Indigenous faculty to build relationships with Indigenous nursing faculty who can advise on how to weave Indigenous perspectives into curricula (Van Bewer et al., 2020). Our findings are consistent with the dire need for non-Indigenous faculty to build collaborative and respectful relationships with local Indigenous communities. Gayatri Spivak’s (1985) concept of the “subaltern” concludes that the ‘subaltern cannot speak’ – to mean that individuals who are marginalized by racism or other socio-political-historical factors try to speak but run up against micro, meso, and macro barriers where their words, ways of knowing, and suggestions are not valued due to intersections of discrimination. As such, non-Indigenous peoples seeking to build collaborative partnerships should not assume that Indigenous peoples cannot speak, lead, or make decisions, rather, non-Indigenous peoples should clear the way for Indigenous peoples to speak, lead, and inform Indigenous health education.

Indigenous faculty in this study noted their observations that students entering nursing programs are further along in their historical knowledge of Indigenous Peoples in Canada compared to their non-Indigenous (white settler) faculty. Historical knowledge is the awareness and understanding of the histories of Indigenous peoples in Canada, the associated laws and societal events that transcended into the current realities and health inequities imposed upon Indigenous peoples in a systemic manner. In this sense, it raises questions as to how faculty are
trained to teach Indigenous health on an institutional level and how individual knowledge and comfort is further honed or developed for faculty to be an effective facilitator in the classroom (Downing & Kowal, 2010; Vass & Adams, 2021).

Some nursing students highlighted the ability of faculty to develop their racial identities as they learn to self-position/locate within the context of their learning environment to challenge one’s preconceived notions of their own racial identities and what that affords or disadvantages them with. This happens in concert with students in the classroom and the way critical reflection is prompted by faculty and learners. Indigenous nursing faculty also allude to their own racial identity development overtime through their teaching and co-learning experiences with nursing students; however, it can be a challenge for white settler faculty, as individuals go through this transformative learning uniquely at their own pace and can be unsettling and uncomfortable to varying degrees. Joy-Corell et al. (2022) highlights challenges for Indigenous persons who feel like they must negotiate their identities in different spaces and the challenge of being an Indigenous ‘expert’, thus being tokenized in the classroom. This aligns with the concept of hybridity once again, where the orient’s or ‘colonized’ identity is adapted, shaped, and intermingles with the colonizer’s world to become not entirely new, but of something familiar. It should be noted that Indigenous Peoples actively resist the encroachment of colonization and remain resilient in the face of cultural genocide and colonial structures. Racial identity development eventually sees individuals being able to relate their social-cultural-political-historical positioning to their peers and integrate ‘praxis-oriented inquiry’. “Praxis is a process of applying knowledge in nursing practice to advance emancipatory goals in society and in the world to eliminate any injustice and discrimination in care” (Rafii, Nasrabadi & Tehrani, 2021, p. 83). Although self-positioning and the ability to develop one’s own racial identity can be
beneficial, postcolonial thought appreciates that they must continue to confront the historical epistemic racism in the learning environment in which we co-create in this third space. Epistemic racism as a colonial mechanism needs to be disrupted, and should be explored to assess how recruitment, training, and supports at institutions are enacted and can be improved upon (Sinclaire, Lavellee, Cyr, & Schultz, 2023). Ongoing professional development for faculty is essential and should be informed by local Indigenous perspectives (Griffith et al., 2007).

**Decentering Whiteness in the Classroom**

White fragility can manifest in the learning environment and requires the faculty to be able to manage and facilitate that. DiAngelo (2018) coined the term *white fragility* to describe the defensive and emotional response from white people when confronted with discussions of racism (Bell, 2022). White fragility can contribute to delays in learning and may be a distancing tactic that serves to avoid accountability in reconciliation. Bell (2022) asserts that this serves to maintain the racist status quo as it inhibits or shuts down attempts for discussion, reflection, and unlearning, to turning it toward mending feelings of white settlers. Hantke, St Denis, & Graham (2022) describes the problem of whiteness within nursing, namely the innocent and superiority whiteness affords individuals and the common patterns observed to move toward innocence and absolve themselves from personal responsibility with racism and Indigenous health inequities. This further aligns with the disavow described in the earlier concept of “sanctioned ignorance” (Spivak, 1999).

Faculty in our study stated that there can be a tension between managing white fragility in the classroom and trying to move the classroom discussion forward for other learners without losing learners in the process. For example, white fragility can manifest in defensiveness, victim mentality, projecting blame, and moves toward innocence by settlers which must be attended to
by the course facilitator or faculty to bring the student(s) back into the learning environment by working through the emotional reaction during or after class. Faculty informants saw this as building intellectual and emotional capacity when successful. This is consistent with DiAngelo’s (2018) notion of building *white stamina*, which is believed to be an antidote to white and settler fragility (Bell, 2022).

Building white stamina begins with learning to reflect rather than deflect (DiAngelo, 2018, p.72), being able to sit with the discomfort of being challenged about racism and privilege, and accepting that we are implicated in a racist system – there is no position of innocence outside race (Bell, 2022, p. 690).

The tensions between being supportive and acknowledging the discomforts versus maximizing class learning outcomes is evident based on the Indigenous faculty’s experiences. Such balancing skills requires any faculty to be attuned with the classroom dynamics and in realizing how their own positionality can contribute greatly to this environment. Students may inadvertently disengage and retreat from participation if they feel targeted due to their whiteness, settler identity, and perceived complicity.

In cases of non-Indigenous (white and settler) faculty teaching Indigenous health, students have acknowledged that the lack of self-positioning can create a challenge in learning as faculty may come across as inauthentic and trying to speak for Indigenous peoples from the students’ perspectives. Nursing educators must understand that nursing education has a culture within itself and that culturally safe learning spaces need to be cultivated for learners to feel safe in questioning, learning, challenging, and expressing (Vass & Adams, 2021). A facilitator espoused was that Indigenous faculty and students add invaluable knowledge and feedback to creating a classroom environment that fosters safe learning. Indigenous voice and representation are necessary in efforts to decolonize, reconcile and Indigenize learning environments. This
requires careful and strategic considerations when it comes to policies in recruitment and retention of Indigenous faculty and students. With respect to the whiteness in nursing, Bell (2021) posits that a “shift in anti-racist efforts away from short-term skill acquisition initiatives towards the deconstruction of socialized white supremacy and enactments of white privilege in nurse educators themselves” is needed (p. 1).

Creating Cultural Safety in the Classroom

Creating cultural safety in the classroom was a fourth theme that emerged through exploring the facilitators for learning Indigenous health. This theme builds on the former theme in that incorporates the concept and framework of cultural safety and adds the foundational tenants needed. According to Moffitt and Durnford (2021) cultural safety is a relational process that “is a means of empowerment through antiracist actions, decolonizing praxis, an understanding of the effects of a colonial history, and reconciliation to an equitable and inclusive place.” (p. 1).

Student participants stated the need for a mutual agreement between educator and learners that sets the tone for the learning environment. For example, a class charter, terms of learning, social contract or something alike that is co-created by the faculty and students at the beginning of the course term may benefit all individuals as it sets the ground rules for respectful interactions and behaviors to prevent microaggressions and unintentional disregard for diversity in perspectives or moments of vulnerability throughout the learning journey (Cruse, 2019).

Class size and time are also essential pedagogical considerations. Universities and Schools of Nursing are incentivized to have increasing enrollments each year, however, this directly impacts the class size per section and creates a didactic environment for learning as opposed to an intimate setting for critical discussions. Time can be seen as a challenge and
facilitator depending on how time is utilized to deliver content and implement opportunities for relational engagement and dialogue. Processing learning was a strong finding in Mills, Creedy, Sunderland, Allen, Carter, & Corporal’s, (2022) study on evaluating Indigenous-led and emotion-based pedagogy to promote culturally safe learning. Our findings are consistent with Mills et al., (2022) in that processing content learned is a necessity to transform learning and become self-reflexive. Students and faculty have found that courses that are heavy in content tend to limit the time available for questions and dialogue. Time is seen as a facilitator when it is used appropriately to prioritize discussions where students can sit and think through their thoughts and allow content or discussion points to reflect upon. Reflective practice has been preached throughout nursing education as that is a professional mandate and a tenant of culturally safe classroom (Moffit & Durnford, 2021; Doran, Wrigley & Rix, 2022) – however, there are seldom opportunities to reflect in a group-setting in the euro-western class pedagogy. Reflective practice can be transformative however, Zembylas (2020) suggests that students and faculty should engage in formalized processes of collective sharing and witnessing. This form of collective critical reflection will prevent students from getting stuck during self-reflexivity, may promote healing from trauma that emerges, and build empathy to understand the socio-political factors that shape inequities for Indigenous peoples. (Mills, Creedy, Sunderland, Allen, Carter, & Corporal, 2021). Our findings are consistent with this as faculty have noted the crucial role they play in classroom discussions when sharing and witnessing. However, our study adds that faculty are spearheading the discussions and must moderate emotional responses and overall dynamic of the classroom.

One faculty member noted the tension with the use of case studies about Indigenous peoples. There have been shifts toward removing case studies, recognizing their potential to
promote stereotyping and perpetuate racism against Indigenous peoples. In examining this phenomenon, case studies were seen as pitfalls to teaching Indigenous health depending on the preparedness of faculty; however, some Indigenous faculty posit that there are benefits to including case studies within the Indigenous health context as it can provoke tough conversations. A faculty member also noted that this may be the only time students have that exposure in a safe learning environment and can learn to implement how to speak up or respond to the case scenario with adequate feedback.

Online learning has exponentially increased due to the COVID-19 pandemic in 2020. The shift to online learning has changed the medium for which learning takes place in a classroom setting to a virtual setting that can be asynchronous or synchronous. Challenges to learning online include accessibility, geographic concerns, sociopolitical context, students not feeling safe to share, and the limitations to building community and relational engagement. Limitations to online learning tell us that online learning can be implemented to some degree but requires thoughtful pedagogical consideration in how we design the course to engage and relate to one another throughout the learning process. It also tells us that the use of online platforms must consider how accessibility is assessed to accommodate students needs proactively, the diversity in learning, and foster a safe and inclusive learning environment for equity deserving groups.

Faculty may have limited experience in online course design as it is often a side project on top of their contract or tenure commitments. As such, there is also a need for faculty development in this arena to fully reap the benefits and create opportunities for fulsome learning on Indigenous health in an online world. The pitfall of online learning is the over reliance on self-directed learning PowerPoint slides where students are navigating content on their own and are to sift through content without being meaningfully engaged in what they are learning; thus
being limited to being inquisitive on how that impacts the care they provide and the patients they work with. There is also limited studies on creating culturally safe learning environment in an online platform regarding Indigenous health education. Faculty involved in implementing online learning is more often based on epistemology that favors Eurocentric ways of knowing. Thus, eurocentrism and individualism assume individual students are responsible for their own learning, resulting in varied learning outcomes.

Relational engagement and critical reflection were facilitators across both group (students and faculty) findings. Relational engagement is the art and a “way of knowing that emerges as [one] develops partnerships with diverse [individuals] in a variety of different contexts; [understanding] each person is unique, requiring [one] to be able to quickly attune to the [person’s] state of being, at all levels – physical, mental, emotional, and spiritual.” (Kaminski, 2013). Relationality for transformation of learning is consistent with the study conducted by Moffitt and Durnford (2021) on nursing students’ perceptions on what necessitates a culturally safe space or brave space to share and learn. The premise of brave spaces assumes that discomfort pedagogy, which is common within Indigenous health education, will inevitably carry the risk of discomfort among other emotions which may cause unsafety (Moffit & Durnford, 2021). As such, our study affirms that creating brave spaces is considered a facilitator and builds on the concept of what constitutes a culturally safe classroom. Critical reflection is “an educational strategy that systematically integrates experiences, praxes, and theories in clinical practice. It narrows the gap between theory and practice and improves professional development and nursing practice based on nurses’ experience because it helps them critically evaluate and change their nursing practice by asking ‘why’, thus expanding their thinking.” (Shin, Hone, Do, Lee, Jung, and Lee, 2022, p.1). Our study’s findings build on this through our
postcolonial lens; in that the ‘why’ needs to be delved into for students to build emancipatory knowing when reflecting on the socio-historical-political context of Indigenous health.

Creating a culturally safe learning environment hinges on students’ perceptions that they are included, accepted for who they are, what they bring, and how they learn. The increase in diversity and the attention nursing research has gravitated toward in intersectionality, warrants the need for diversity and inclusion in learning and evaluation. Teaching to the (class or license registration) test(s) may limit nuanced ways of approaching issues related to Indigenous health. Instead, flexibility in course content and resources have been stated as facilitators as students can chose how they take up the content or preliminary learning activities. The Eurocentric institution can still run into problems of microaggressions and white fragility in the classroom, as such, there should be mechanisms in place for feedback and safe opportunities for students to help co-create and facilitate the learning as the course progresses (Tujague & Ryan, 2021). Faculty have highlighted the tensions that they have experienced with students who are disengaged and show strong disavowal toward learning Indigenous health. These can be opportunities to understand why and to meet learners where they are at, however, this is dependent upon the faculty’s skills in assessing, enacting cultural humility, and finding alternative ways to reach the student(s).

Lastly, creating a culturally safe classroom must incorporate critical perspectives such as postcolonial, critical, feminist, and Indigenous ways of knowing. The pedagogy should also be trauma-and-violence informed, as many students come into the program may have varying levels of trauma from experience and may be resistant to participate due to fear of judgement and being psychologically triggered (Browne, Varcoe, Lavoie, Smye, Wong, & Krause, 2016; Tujague & Ryan, 2021). Browne et al. (2016) caution the use of the concept of trauma as it may obscure the ongoing impacts of structural violence (historic and ongoing violence) and inadvertently
pathologize Indigenous peoples. When integrating trauma and violence informed (TVIC) lens, our findings suggest that students and faculty have an imperative to learn TVIC to meet their classmates where they are at - knowledge wise, emotional or comfort status, and ways of knowing/learning.

**From Classroom to Practice**

Despite the learnings from classroom, students and faculty have made clear that the translation into practice settings remains the ultimate challenge in addressing anti-racism on Indigenous and racialized patients (Downing & Kowal, 2010). This finding was particularly important to note as nursing education transcends classroom walls and individuals are socialized to become a nurse in health care institutions. Interpersonal and institutional racism have been highlighted, however, there remains a larger tension and pitfall when structural racism enables racism on all levels to persist. For example, students highlighted the backlash they inadvertently faced when they made complaints about a nursing faculty or a nurse they were paired with in the clinical setting. Students stated they were silenced, and the complaint(s) were said to be minimally addressed but later forgotten about by the academic and/or healthcare institution’s chain of command. This aligns with Indigenous faculty’s reports that learning in vacuum (classroom) has its limitations because of the institutional and structural racism that enables bystander effect (Auld, 2018; Priest et al., 2021) or as postcolonial theorist Spivak would conceptualize this as “sanctioned ignorance”. This calls into question the sustainability of learning when learners are met with challenges such as the inherent structural racism to apply what they have learned into practice.

Institutional racism can be deeply ingrained, as is structural racism (Auld, 2018). It requires an anti-racist approach by all stakeholders that specifically names racism as a colonial
hegemony. This is often a challenge for most white settler leaders whose comfortability remains neutral or strays away from talking about racism at all costs. Representation is therefore a needed change that can promote an anti-racist paradigm shift in organizations/institutions (Richardson & Syring, 2022). White settlers in positions of power may be reluctant to share the power but must be trained to understand the importance of the 4 R’s: respectful collaboration, reciprocity, responsibility, and relevance when working with Indigenous peoples and communities (Kirkness & Barnhardt, 2001). Structural changes call for collaboration of academic and practice partners to create policies and procedures that are equity-oriented and led by local Indigenous communities, Elders, and leaders. It involves the deliberate process such as evaluating the current hiring processes, funding disbursements to sustain Indigenous initiatives until its normalized, and creating supports to help faculty and students who are Indigenous and racialized thrive in the academic and practice environment. Relationship building will take time and patience but is essential to realize the true potential of anti-racism, reconciliation, decolonization, and Indigenization (Richardson & Syring, 2022).

Academic and clinical practice settings would benefit from implementing non-retaliation reporting systems that offsets power differentials (Auld, 2018) and allow equity-deserving individuals to report discrimination whether that is racially, ethnically, religiously, disability, or sexuality motivated, without fear of retaliation, academic set back, losing their job, or being treated with incivility. In an Australian pilot study by Priest et al. (2021), reporting systems may challenge interactional/interpersonal racism, but may prove to be difficult to dismantle institutional/structural racism. Reporting systems are also a step toward enacting social justice and human rights in these settings. However, the success of such systems calls for social, ethical, and political will. Hiring an Anti-Racist Contact Officer may support reporting, investigation,
follow up, and disciplinary tasks. Further research on antiracism reporting system would be
-crucial for academic and practice settings and may contribute to aggregate data overtime to
demonstrate its successes and areas of improvement (Priest et al., 2021).

Moreover, the use of reporting systems can enable racialized students to also come forward
and promote anti-racism in the academic and practice institutions. Spivak (1999) conceptualizes
this as “strategic essentialism”, whereby individuals who are marginalized or in subordinated
groups come together to simplify group identity to counter colonial expectations, such as
individuals who are subject to racial discrimination can mobilize on the basis of racial identity
and represent themselves. While strong differences may exist between members within the
group, it sometimes may be advantageous for them to temporarily “essentialize” themselves,
even if it may be based on erroneous logic (Kurzwelly, Rapport, & Spiegel, 2020). This
temporary strategic essentialism may lend way to achieve certain group goals such as anti-
racism, human rights, and social justice.

**Strengths and Limitations of this Study**

This study has several strengths. Firstly, the study may be easily reproduced to explore
other settings and outcomes of learning Indigenous health. Secondly, the validity of the findings
has been member checked by informants and confirmed by other sources such as nursing
students at other schools of nursing, and at conference presentations. Overall, it adds to our
understanding of what’s happening in the country and adds critical lens in the Canadian context
to ways we can improve and implement the Calls to Actions 22-24. Schools of Nursing can
actively reflect on this study to its own institution’s path towards decolonization, reconciliation,
and Indigenization. Schools of Nursing can implement facilitators named in this study and
improve upon challenges noted.
The study’s limitations include the COVID-19 pandemic and the resultant global restrictions on non-essential travel, activities, and an overarching shift to virtual platforms for work and academia. This limited the study’s ethnographic methodology in that classroom observations could not take place and interviews were conducted mainly by phone or online meeting rooms. ‘Zoom fatigue’ may have contributed to the low uptake throughout the study’s multiple attempts at recruitment. Participants affected by the shift to online learning identified limitations in their learning experience as it was ‘not what it was supposed to be’ in terms of the Indigenous health content or course that had historically been an in-person session or course. COVID-19 pandemic created a shift to technology uptake that needed to be adapted to quickly, thereby, students and faculty who may not have the privilege to afford such technicalities may have been unintentionally excluded to an extent. As well, time and technological challenges in terms of user knowledge and skills may have diminished faculty’s ability to apply intentional pedagogical considerations to the Indigenous health content where critical reflection and relational engagement would have been facilitated the learning. Participants were also predominantly from one school of nursing out of the four schools where sampling occurred therefore, the accounts of student experience may not be generalized across all sampling sites. However, research team members triangulated data from faculty responses which may provide a more nuanced understanding of nursing students’ learning experiences.

The lack of comparison of Indigenous vs. non-Indigenous nursing students’ experiences of learning Indigenous health or on key issues such as cultural safety or differing experiences of racism is another limitation of this study.

Lastly, the sample size may be a limitation in transferability of the results due to response bias as informants in the study may have been strongly dissatisfied or satisfied with their
experiences and desired the ability to make a change. Despite the sample size, the information power is arguably high. Information power “indicates that the more information the sample holds, relevant for actual study, the lower the number of participants is needed.” (Malterud, Siersma, & Guassora, 2016, p. 1753). Participants provided ample breadth and depth in information regarding their learning experiences. Interviews were approximately 20-90 minutes, with more in 60 minutes or longer. Despite the small sample size, the informants’ responses enabled the research team to draw multiple themes that transcended almost all transcripts, thus demonstrating the relevance and high information power. Furthermore, the study was informed by theory, specific in field of study, generous dialogue with triangulation, and included in-depth exploratory mode to analyses drawn. These findings are not generalizable to all learning experiences of Indigenous health education in nursing programs but could be used to inform future research and education.

**Implications**

Without naming anti-racism on an institutional level, the lines of learning about ‘other’ culture(s), theoretical concepts, and lack of processes and transparency of policies and processes in addressing racial incidences, are blurred and remain impractical for nursing students. Enacting an anti-racist and decolonizing approach to education, practice, policies, procedures, and training places accountability on all levels of the school of nursing and educational institutions. Nursing students need to be equipped to advocate for anti-racism in their work and the care of Indigenous patients. Implications for education, policy, clinical practice, and research will be elaborated on.

**Education**

Anti-racism is a term, concept, and active process that can be difficult to name and implement in Canadian schools of nursing. The instilled tolerance of neocolonialism and
perceived essentialist, culturalist, and multiculturalist ideology dominates and hinders progress on anti-racist stance and education in nursing education. Nursing faculty and students who identify as Indigenous are in this matrix of having to advocate for anti-racism while meeting student defensiveness (and sometimes hostility) and risk potential harm through re-traumatization and white fragility. White fragility is a term coined by Robin DiAngelo to describe white people’s discomfort when discussing about racism. Pedagogy, in essence, requires the will power and iterative feedback processes that instill an anti-racist stance and the fruitful collaboration of Indigenous knowledge and western knowledge systems. Decentering whiteness in nursing warrants and anti-racist stance, appreciating Indigenous worldviews, and having the necessary structures in place that support Indigenous students, faculty, staff to thrive in the program and beyond that.

Nursing education would benefit from respectful collaboration with local Indigenous communities. Non-Indigenous peoples should be partners in teaching Indigenous health education from a place of whiteness or their own respective racial identity and acknowledge their self-location in doing so. Professional development opportunities for faculty are warranted to bring non-Indigenous faculty up to date on the histories of Indigenous health and their contributions and complicity to the neo-colonial practices today. Faculty need to practice self-reflection and be reflexive of their ways of knowing and teaching to avoid perpetuating essentializing stereotypes and further harm. This learning and un-learning is critical, and understanding should be fostered that they are co-learners in the learning environment despite the power they hold as “educators”. This will require faculty to relinquish their position of privilege and power to practice humility in confronting white supremacy in nursing and to make
space for Indigenous voices and worldviews; also known as being comfortable with being uncomfortable.

Indigenous faculty should be supported to indigenize the curriculum and schools of nursing to bring about safe spaces that foster belonging and indigenization. This includes fair compensation of faculty, Elders, and community members; resources; space; and active welcoming of Indigenous authors, research work, content matters, pedagogy, and andragogy.

Schools of nursing and faculty members should caution against the act of habitually ‘deferring’ all matters that involve Indigenous health to any named ‘Indigenous’ committees or groups, where Indigenous persons or faculty must take on matters that may or may not be appropriate for such committees or groups. Instead, leaders and settler faculty or staff at schools of nursing and institutions should reflect inwardly and critically assess why matters are being deferred and take accountability in the work that may inevitably be uncomfortable. Equitable work distribution should also be assessed regularly as Indigenous faculty may take on additional workloads that are curriculum based and non-curriculum based.

Strategies including race-based or racial caucusing should be considered in the classroom and strategically implemented. Classroom contracts that detail the terms and lay the foundation for ways of approaching anti-racism and Indigenous health education may help create a psychologically safe classroom. Faculty should teach from a strengths-based perspective that acknowledges the resilience of Indigenous peoples rather than solely focusing on pathologies or adverse discourses. It would also necessitate that faculty who teach within nursing education are well-aware of the resources and services available for individuals who need support during the learning process. Ongoing feedback should be solicited during the course of learning and after the course of learning whereby students or other faculty can provide anonymous feedback to
improve upon pedagogies and overall curriculum on Indigenous health. Feedback should be tracked, implemented and evaluated to assess the impact and ways to continuously improve.

**Policy**

Anti-racist policies and procedures within healthcare professional programs, education institutions, partner clinical institutions, and relevant community partners should be reviewed, reformed, or created with local Indigenous community input. Policies that warrant ongoing review and approval should be mandated to ensure that feedback processes continue to inform the changing landscape of critical anti-racism work for Indigenous peoples and people of color. Policies need to name anti-racism instead of non-controversial terms and have accountability measures that protect Indigenous peoples and persons of color who come forward to report acts of racism. Non-retaliation clauses and policies should be strongly emphasized for students, faculty, nursing staff, and all leadership to ensure no incident reports regarding acts of racism result in retaliation, firing, demoting, social exclusion, and incivility in academic and clinical practice institutions. These policies should be included in orientation and reviewed on a regular basis to become normalized. Hiring practices, promotion practices, and qualifications that diminish opportunities for Indigenous peoples should be made equitable. Sanctioned ignorance should be challenged in this regard when it comes to hiring and promoting. Procedures for evaluation, reporting, and follow up should be transparent and be open to critique from individuals it effects the most. Anonymous incident reporting systems should be established to create a sense of safety for Indigenous peoples and persons of color who experience racial discrimination or acts of racism.
Clinical Practice

Implications for clinical practice start with professional practice environments during students’ training in nursing and healthcare programs that involve applying knowledge gained through class, simulation, and clinical placements. Within these clinical settings the students are paired with licensed nurse mentors who mentor them during that shift or rotation throughout the term. Nursing students often struggle with power dynamics when speaking up about issues of discrimination – particularly those that are race-motivated.

The schools of nursing must ensure that preceptors or nurse mentors who are working closely with students have adequate training and awareness of anti-racism policies and procedures. Healthcare and education institutions or settings need to collaborate to develop anti-racist, anti-oppression, and decolonizing policies and procedures to support the translation of classroom learning into practice. Clinical advisors or persons may need to be employed by the school of nursing to work within practice settings to be an advisor that can level the power dynamics and be trained to provide appropriate support for nursing students in navigating reporting systems and developing consistencies across policies and procedure.

Research

Research implications include the need to further explore how learning outcomes from Indigenous health education affect health care outcomes of Indigenous peoples in clinical settings. The knowledge translation from classroom to practice has been strongly highlighted. Further research should also explore how introduction of digital or virtual learning methods can benefit or create challenges for faculty and students, and the sustainability of learning Indigenous health overtime. Research will also be necessary to study the effects of incident reporting
mechanisms in that statistics and annual reports should be made public to education and clinical institutions to identify areas for improvement.

This research mainly highlighted the ways Indigenous health was taught, however, more research that takes up the standpoint of how racialized students and faculty experience these new discourses around anti-racism and anti-oppression should be conducted.

**Conclusion**

Indigenous health education reform requires efforts beyond individual level training. The Truth and Reconciliation Calls to Action set the stage to dismantle the colonial history of interpersonal, institutional, and structural racism. Non-Indigenous and Indigenous peoples must decolonize, reconcile, Indigenize, and enact Anti-racism on all fronts that permeate education, policy, research, and practice. This study provides implications and strategies that may facilitate critical dialogue and relational engagement to foster transformative learning in students learning Indigenous health. Partnering with Indigenous peoples, community, and organizations remain essential in the much-needed relationality of the work. Academic and clinical practice institutions must also collaborate to create policies that support anti-racism and anti-oppression that fosters safe spaces for learning and practice where knowledge translation of Indigenous health can occur seamlessly. The work remains ongoing and health care professionals are accountable to bettering and humanizing the landscape of care for all Indigenous peoples and persons of color. Education is a political act and one that requires more accomplices in dismantling the colonial structures of violence.
References


https://doi-org.proxy1.lib.uwo.ca/10.1016/j.profnurs.2016.05.007


https://doi-org.proxy1.lib.uwo.ca/10.3928/01484834-20200520-03

https://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa


https://doi-org.proxy1.lib.uwo.ca/10.17269/s41997-021-00598-1


University of Alberta. doi:10.1177/160940691501400107


https://doi-org.proxy1.lib.uwo.ca/10.1111/nin.12531


Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). “They treated me like crap and I know it was because I was native”: The healthcare experiences of aboriginal peoples living in Vancouver’s inner city. *Social Science & Medicine, 178*, 87-94. doi:10.1016/k.socscimed.2017.01.053


doi:10.1080/10401334.2016.1234960


Dissertations & Theses Global. (1511468092). Retrieved from

https://bcmj.org/sites/default/files/BCMJ_Vol63_No8-bcmd2b.pdf


https://doi.org/10.1186/s12889-021-11469-2


https://doi-org.proxy1.lib.uwo.ca/10.1016/j.socscimed.2021.114422


https://doi.org/10.1186/s12904-019-0404-y


https://doi.org/10.1016/j.cjco.2021.09.010


https://doi-org.proxy1.lib.uwo.ca/10.1016/S0140-6736(22)02304-2


https://doi.org/10.3390/ijerph20043288


https://doi.org/10.1177/0034523719890367

Appendix A

Semi-Structured Interview Guide

Student Guide

1. First, tell me a little about yourself and why you agreed to be in this study.

2. Can you tell me about your experiences of learning about Indigenous health in your nursing program and the university?

3. What factors do you believe helped facilitate your learning experiences of Indigenous health for you? (people/environment/past experiences)

4. What factors challenged your ability to learn about Indigenous health?

5. Have you had an experience in clinical or professional practice where you felt your learning of Indigenous health was applicable in any way? How did you respond?

6. What are your understandings of the notion of ‘culture’ and how has that understanding been influenced by your educational experience? How do you take up this understanding in practice?

7. What do you see as the stance of your School on the issue of Indigenous health and how do you see this being lived out? How do you see that influencing your learning process?

8. Is there anything else that you would like to tell me about your experiences?

9. Would you like to be contacted with the study’s findings and review?
Nursing Faculty Interview Guide

1. First, tell me a little bit about yourself and why you agreed to be in this study. Where are you from and how long have you been a nurse educator?

2. Please tell me about your experiences of teaching Indigenous health content.

3. What factors facilitated your ability to teach Indigenous health?

4. What factors have challenged your ability to facilitate learning of Indigenous health for nursing students?

5. Is there anything else that you would like to share with me about your experience of teaching IHC or your observations of nursing students’ responses to learning IHC?

6. Would you like to have follow up after the data collection period and be involved in the analysis/member checking?
Appendix B

Findings – Themes Elicited

1. Encountering Racism in Education and Practice
   - Theory to Practice Gap
   - Racism in the classroom
   - Racism in Clinical Practice

2. Need for Faculty Development
   - Lack of Representation
   - Faculty’s Preparedness and Knowledge to Teach Indigenous health
   - Faculty’s Racial Identity Development

3. Decentering Whiteness in the Classroom
   - White Fragility in the Classroom
   - Challenges in Positioning One-self
   - Cultural Safety in Classroom

4. Creating Cultural Safety in the Classroom
   - Readying the Classroom
   - Class Size
   - Time for Critical Reflection
   - Online Learning
   - Choice and evaluation of learning

5. From Classroom to Practice
   - Facing Backlash in Practice
   - Sustainability
   - Structural Changes
Appendix C

Recruitment Emails

Subject Line: Request to distribute Invitation to participate in research study

Hello [name of contact person at the respective school of nursing],

I hope this email finds you well. My name is Ivy Tran and I am a Master of Science in Nursing student at Western University. Dr. Vicki Smye, my thesis supervisor, has made initial contact with [insert name of initial contact person] and we would like to kindly ask for your assistance in distributing the invitation to participate in the research study to undergraduate nursing students enrolled in the Collaborative and Compressed-Time Frame programs. There is also a second email for faculty/instructors to be distributed. Please see the emails below to copy and paste with the attached posters to the respective recipients. Please include my email in the cc’ed field and let me know once you have distributed the email.

If possible, I would like to ask if you could further assist in posting the posters in the hall ways or high traffic bulletin boards that nursing students and faculty/instructors may come across in their commute to classes and offices.

Please let me know if you have any questions.

Thank you for your help, I greatly appreciate it!

Ivy Tran, RN
[Email]
Arthur Labatt Family School of Nursing
Western University
Hello nursing students,

You are being invited to participate in a study that we, Dr. Vicki Smye and Ivy Tran, are conducting on nursing student’s experiences of learning Indigenous health. Briefly, the study involves semi-structured individual interviews, for two sessions (one being the initial interview, and for a follow up member check to confirm construction of participant’s intended meaning). The duration of the study will range between two to four months with two points of contact ranging between 30-60 minute sessions per contact.

If you would like to participate in this study please click on the link below to access the letter of information and survey link.

[Qualtrics Survey link to the eligibility to participate survey and Letter of Information and Consent]

Thank you,

Dr. Vicki Smye, RN, PhD
Arthur Labatt Family School of Nursing, Western University
[Email]

Student Contact: Ivy Tran, BScN, RN
Email: [removed]
Affiliation: Arthur Labatt Family School of Nursing, Western University
Subject Line: Invitation to participate in research on Indigenous health education in Nursing education

Hello nursing faculty and instructors,

You are being invited to participate in a study that we, Dr. Vicki Smye and Ivy Tran, are conducting on nursing student’s experiences of learning Indigenous health. Briefly, the study involves semi-structured individual interviews, for two sessions (one being the initial interview, and for a follow up member check to confirm construction of participant’s intended meaning). The duration of the study will range between two to four months with two points of contact ranging between 30-60 minute sessions per contact. Faculty and instructors who teach Indigenous health course and/or content are being invited to provide your perspectives on the teaching and uptake of Indigenous health education.

If you would like to participate in this study please click on the link below to access the letter of information and survey link.

[Qualtrics Survey link to the eligibility to participate survey and Letter of Information and Consent]

Thank you,

Dr. Vicki Smye, RN, PhD
Arthur Labatt Family School of Nursing, Western University
[Email]

Student Contact: Ivy Tran, BScN, RN
Email: [removed]
Affiliation: Arthur Labatt Family School of Nursing, Western University
Appendix D

Letter of Information and Consent Forms

Student Version

RE: Invitation to Participate in Study on Learning Indigenous Health in Nursing Education

Dear Potential Participant:

You are invited to participate in a research study about undergraduate nursing students’ experiences of learning Indigenous health content in nursing education because you are a current nursing student and may be able to provide unique insights on your learning experience.

Taking part in this study is voluntary. Before you decide whether or not you would like to take part in this study, please read this letter carefully to understand what is involved. After you have read the letter, please ask any questions you may have.

Please note that voluntary participation or non-participation will have no impact on your academic status or relationship at [Name of University] or Western University.

<table>
<thead>
<tr>
<th><strong>Canadian Undergraduate Nursing Students’ Experiences of Learning Indigenous Health Content</strong></th>
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<tbody>
<tr>
<td><strong>Letter of Information and Consent - Student</strong></td>
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<tr>
<td><strong>Principal Investigator:</strong></td>
</tr>
<tr>
<td>Dr. Victoria Smye, RN, PhD</td>
</tr>
<tr>
<td>Arthur Labatt Family School of Nursing, Western University</td>
</tr>
<tr>
<td>[Email]</td>
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<tr>
<td>[Phone]</td>
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<tr>
<td><strong>Research Staff:</strong></td>
</tr>
<tr>
<td>Ivy Tran, BScN, RN, MScN Student</td>
</tr>
<tr>
<td>Arthur Labatt Family School of Nursing, Western University</td>
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<td>[Email]</td>
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<td>[Number Provided]</td>
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<tr>
<td><strong>Conflict of Interest</strong></td>
</tr>
<tr>
<td>The investigators declare no conflict of interest.</td>
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<tr>
<td><strong>Invitation to Participate</strong></td>
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<tr>
<td>You are invited to participate in a research study about undergraduate nursing students’ experiences of learning Indigenous health content in nursing education because you are a current nursing student and may be able to provide unique insights on your learning experience.</td>
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<tr>
<td><strong>Why is this study being done?</strong></td>
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The purpose/objectives of this study are:

- To describe undergraduate nursing student experiences of learning Indigenous health.
- To describe the facilitators and challenges to learning Indigenous health.
- The findings will inform nursing education, leadership, research, clinical practice, and policy.

**How long will you be in this study?**

It is expected that you will be in the study for two to four months. There will be two study visits during your participation in this study and each visit/session will take approximately 30-60 minutes.

**What will happen during this study?**

**Inclusion criteria:**

- Current undergraduate nursing student enrolled in a collaborative or compressed-time frame BScN program
  - Have undertaken a course specific to Indigenous health
  - OR have undertaken a course that has Indigenous health content

**Exclusion Criteria:**

- Non-English Speaking
- Have not undertaken an Indigenous health course or a course with Indigenous health content

**Number of Participants**

It is anticipated that 10-12 nursing students across three Canadian schools of nursing will participate in the study. If the recruitment receives more than the anticipated number of participants, and if feasible, a theoretical sample of a group of students will be anticipated post individual interviews.

**What are the study procedures?**

You will be contacted and asked to complete an online demographic survey. Following that, you will be asked to participate in a 30-60 minute individual semi-structured interview and a follow up 30-60 minute member check through tele-conference after the analysis stage of the study. All Interviews will be audio-tape recorded. This is mandatory. Participants consent to the audio-recording when consenting to participate.

Participants will be encouraged to only answer those questions that they are comfortable with.

The initial interview will take virtually through video-conferencing. Only audio recording will be used to record your voice and responses. Video-recording of you (your personhood) during the video-conferencing will not be used.

A secured room will be booked at your university/institution for the individual interviews and potential theoretical focus group. Alternative off-campus private spaces and
accommodations may be made if accessibility is an issue. The research team member will communicate locations of meeting with you once it is set up.

<table>
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<tr>
<th>What are the risks and harms of participating in this study?</th>
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<tr>
<td>The possible risks and harms to you may include:</td>
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<tr>
<td>• Possible uncomfortable feelings of talking about personal experience</td>
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<tr>
<td>• Feelings of anger, distrust, or frustration with current systems and histories of colonial practices and the related intergenerational trauma of western education and practices</td>
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<tr>
<td>• Feeling inadequate about personal knowledge about Indigenous health and providing service to individuals who identify as Indigenous</td>
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<tr>
<td>• Feelings of uncertainty of translating learned knowledge into practice</td>
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<tr>
<td>• Other possible emotional challenges or anxiety in overcoming colonial ways of thinking or doing in health care</td>
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<tr>
<th>How will the risks and harms be minimized and managed?</th>
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<tr>
<td>To minimize risks and harms, participants are encouraged to answer questions they are comfortable with answering. During the member checking, participants may review their responses to ensure their responses are reflected accurately within the analysis and interpretation of the research staff. After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.</td>
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The above risks will be managed by ensuring nursing students and faculty/professors have access to the appropriate campus and regional resources for support. The resources will encompass ones listed on [Name of University’s] website: [Link directed to University’s wellness and or mental health resource page]

<table>
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<th>What are the benefits?</th>
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<tr>
<td>You may not directly benefit from participating in this study, but information gathered may provide benefits to society as a whole which include, informing Canadian schools of nursing, nursing practice, nursing research, and health policies related to implementing the truth and Reconciliation Calls to Actions. In particular, calls to action #22, 23, and 24, as it relates to health professions and providing a safe health care provision for Indigenous Peoples accessing health care.</td>
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Calls to Actions #22-24 are as outlined:

#22: We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

#23: We call upon all levels of government to:
  i. Increase the number of Aboriginal professionals working in the health-care field.
  ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all healthcare professionals.

#24: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

**Can participants choose to leave the study?**

If you decide to withdraw from the study, the information that was collected prior to you leaving the study will be withdrawn as well and will not be used in the study or published. No new information will be collected without your permission.

**How will participants’ information be kept confidential?**

Representatives of Western University’s Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

Your demographic survey responses will be collected through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western’s Qualtrics server is in Ireland, where privacy standards are maintained under the European Union safe harbour framework. The data will then be exported from Qualtrics and securely stored on Western University's server.

Identifiable information such as your Indigenous status, if applicable, will be collected through the demographics survey for the purpose of ensuring the sample is representative of Indigenous and non-Indigenous perspectives. This information will solely be accessed by the research supervisor (principal investigator) and the research staff (Master Student). This information will be de-identified and represented as an overall percentage in the thesis report.

Please note identifying information (i.e. consent forms and master list) is stored separately from the data collected. The master list will be destroyed when data collection is complete and it is no longer required.

The researcher will keep all personal information about you in a secure and confidential location at Western University (ie. With the Principal Investigator) for seven years. During the study and throughout data collection and analysis, a list linking your study number/pseudonym with your name [and other identifiers if applicable, such as contact information] will be kept in a password protected file on the research staff’s OneDrive, separate from your study file. If the results of the study are published, your name will not be used.

Your audio-recordings and verbatim transcripts of the recordings will be kept in the researcher’s secured OneDrive during the study. All files will be kept for seven years with
the principal investigator in a secured location at Western University after the study is complete.

Direct and indirect quotes will be de-identified and used in the thesis report and manuscript, where applicable. All quotes, both direct and indirect, by participants will be coded to ‘NS1’: “insert quote”, ‘NS2’: “insert quote”, ‘NS3’: “insert quote”, and so forth. No names will be used and content within the quotes will be ensured to uphold confidentiality of any and all individuals (names or identifiers of students), organizations (local or known identifiable partners), and institutions (name of schools, hospitals, etc.).

Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of (theoretical) focus groups, if applicable in your case and this study, prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants and not repeat what is said in the (theoretical) focus group to others.

**Future Uses:**
All identifiable information will be deleted from the dataset collected so that individual participant's anonymity will be protected. The de-identified data will be accessible by the study investigators as well as the broader scientific community. More specifically, the data will be made available to other researchers upon publication so that data may be inspected and analyzed by other researchers. The data that will be shared on the School of Nursing at Western University’s database will not contain any information that can identify you.

**How can I receive a copy of the research results?**
Dissemination of the research results will ensure anonymity and all responses will be de-identified. Participants may request a copy of the research results and the student researcher will send a copy to the appropriate email address.

**Are participants compensated to be in this study?**
You will not be compensated for your participation in this research. A broad thank you acknowledgement will be made in the thesis manuscript/publication for all participants in the study. No individual names or identifiers will be mentioned.

**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. You do not waive any legal right by consenting to this study.

After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.

We will give you any new information that may affect your decision to stay in the study. If you are a First Nations or an indigenous person who has contact with spiritual 'Elders', you may want to talk to them before you make a decision about this research study.
**Ethics Review**

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 (519) 661-3036, 1-844- 720-9816, email: ethics@uwo.ca. 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 research study has been reviewed and approved by [Name of University’s] University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact the Research Ethics Board at [Number to REB at University] or [Email to REB staff].

<table>
<thead>
<tr>
<th>Whom do participants contact for questions or to withdraw?</th>
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</thead>
<tbody>
<tr>
<td>If you have questions about this research study please contact:</td>
</tr>
<tr>
<td>Principal Investigator: Dr. Victoria Smye, RN, PhD</td>
</tr>
<tr>
<td>Phone Number: [Removed]</td>
</tr>
<tr>
<td>Email Address: [Removed]</td>
</tr>
<tr>
<td>Master Student: Ivy Tran, RN, MScN Student</td>
</tr>
<tr>
<td>Phone Number: [Number Provided]</td>
</tr>
<tr>
<td>Email Address: [Removed]</td>
</tr>
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</table>

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

**Written Consent Form**

Please print off and complete the Written Consent form if you are willing to participate. You may scan and email the signed form to the research staff (Master’s Student – Ivy Tran). The completed written consent form will be emailed back to you and a copy kept in a secured file with the research team, separate from the data collected.

Please note there may be a potential loss of anonymity with sending consent forms via email and the research staff will take all precautions to minimize loss, including: viewing email correspondences in a private space, ensure regular password updates, and placing emails in appropriate folders that will intentionally be mislabeled to limit access.
## Written Consent Form

### Canadian Undergraduate Nursing Students’ Experiences of Learning Indigenous Health Content

#### Letter of Information and Consent – Student

**Principal Investigator:**
Dr. Victoria Smye, RN, PhD  
Arthur Labatt Family School of Nursing, Western University  
[Email]

**Research Staff:**
Ivy Tran, BScN, RN, MScN Student  
Arthur Labatt Family School of Nursing, Western University  
[Email]

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

**MY CONSENT:**
I agree to the following:
- ✓ I have read and understand the information contained in the Information Letter
- ✓ I agree to participate and be audio-recorded in this research
- ✓ I understand the risks and benefits to the study
- ✓ That I am a volunteer and can withdraw from the study at any time and may choose not to answer any question
- ✓ That the data will be securely stored at Western University for a minimum period of 7 years following completion of the research project
- ✓ I understand that the research findings will be made available to me upon request
- ✓ I will remain anonymous in the use of unidentified quotes obtained during the study in the dissemination of this research
- ✓ All of my questions have been answered

<table>
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<tr>
<th>Print Name of Participant</th>
<th>Signature</th>
<th>Date (DD-MMM-YYYY)</th>
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My signature means that I have explained the study to the participant named above. I have answered all questions.

<table>
<thead>
<tr>
<th>Print Name of Person Obtaining Consent</th>
<th>Signature</th>
<th>Date (DD-MMM-YYYY)</th>
</tr>
</thead>
</table>
Faculty Version

RE: Invitation to Participate in Study on Learning Indigenous Health in Nursing Education

Dear Potential Participant:

You are invited to participate in a research study about undergraduate nursing students’ experiences of learning Indigenous health content in nursing education because you are a current professor/faculty/instructor who teaches Indigenous health content and may be able to provide unique insights on the teaching experience.

Taking part in this study is voluntary. Before you decide whether or not you would like to take part in this study, please read this letter carefully to understand what is involved. After you have read the letter, please ask any questions you may have.

Please note that voluntary participation or non-participation will have no impact on your academic status or relationship at [Name of University] or Western University.

---

**Canadian Undergraduate Nursing Students’ Experiences of Learning Indigenous Health Content**

**Letter of Information and Consent – Faculty/Instructor**

**Principal Investigator:**
Dr. Victoria Smye, RN, PhD
Arthur Labatt Family School of Nursing, Western University
[Email]
[Phone Number]

**Research Staff:**
Ivy Tran, BScN, RN, MScN Student
Arthur Labatt Family School of Nursing, Western University
[Email]
[Phone Number]

**Conflict of Interest**
The investigators declare no conflict of interest.

**Invitation to Participate**
You are invited to participate in a research study about undergraduate nursing students’ experiences of learning Indigenous health content in nursing education because you are a current professor/faculty/instructor who teaches Indigenous health content and may be able to provide unique insights on the teaching experience.

**Why is this study being done?**
The purpose/objectives of this study are:

- To describe undergraduate nursing student experiences of learning Indigenous health.
To describe the facilitators and challenges to learning/teaching Indigenous health.
The findings will inform nursing education, leadership, research, clinical practice, and policy.

How long will you be in this study?
It is expected that you will be in the study for two to four months. There will be two study visits during your participation in this study and each visit/session will take approximately 30-60 minutes.

What will happen during this study?
Inclusion criteria:
- Current faculty/instructor teaching in the undergraduate nursing collaborative or compressed-time frame BScN program
- Currently teaching/have taught a course specific to Indigenous health
- OR currently teaching/have taught a course that has Indigenous health content

Exclusion Criteria:
- Non-English Speaking
- Not currently teaching/have not taught an Indigenous health course or a course with Indigenous health content

Number of Participants
It is anticipated that 3-5 instructors/faculty/professors across three Canadian schools of nursing will participate in this study.

What are the study procedures?
You will be asked to participate in a 30-60 minute individual semi-structured interview and a follow up 30-60 minute member check through tele-conference after the analysis stage of the study. All Interviews will be audio-tape recorded. This is mandatory. Participants consent to the audio-recording when consenting to participate.

Participants will be encouraged to only answer those questions that they are comfortable with.

The initial interview will take virtually through video-conferencing. Only audio recording will be used to record your voice and responses. Video-recording of you (your personhood) during the video-conferencing will not be used.

A secured room will be booked at your university/institution for the individual interviews and potential theoretical focus group. Alternative off-campus private spaces and accommodations may be made if accessibility is an issue. The research team member will communicate locations of meeting with you once it is set up.

What are the risks and harms of participating in this study?
The possible risks and harms to you may include:
- Possible uncomfortable feelings of talking about personal experience
- Feelings of anger, distrust, or frustration with current systems and histories of colonial practices and the related intergenerational trauma of western education and practices
- Feeling inadequate about personal knowledge about Indigenous health and providing service to individuals who identify as Indigenous
- Feelings of uncertainty of translating learned knowledge into education or practice
- Other possible emotional challenges or anxiety in overcoming colonial ways of thinking, education, or doing in health care

### How will the risks and harms be minimized and managed?

To minimize risks and harms, participants are encouraged to answer questions they are comfortable with answering. During the member checking, participants may review their responses to ensure their responses are reflected accurately within the analysis and interpretation of the research staff. After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.

The above risks will be managed by ensuring nursing students and faculty/professors have access to the appropriate campus and regional resources for support. The resources will encompass ones listed on [Name of University’s] website: [Link directed to University’s wellness and or mental health resource page]

### What are the benefits?

You may not directly benefit from participating in this study, but information gathered may provide benefits to society as a whole which include, informing Canadian schools of nursing, nursing practice, nursing research, and health policies related to implementing the truth and Reconciliation Calls to Actions. In particular, calls to action #22, 23, and 24, as it relates to health professions and providing a safe health care provision for Indigenous Peoples accessing health care.

Calls to Action #22-24 are as follows:

**#22**: We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

**#23**: We call upon all levels of government to:
   i. Increase the number of Aboriginal professionals working in the health-care field.
   ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
   iii. Provide cultural competency training for all healthcare professionals.

**#24**: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and
Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

<table>
<thead>
<tr>
<th>Can participants choose to leave the study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you decide to withdraw from the study, the information that was collected prior to you leaving the study will be withdrawn as well and will not be used in the study or published. No new information will be collected without your permission.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How will participants’ information be kept confidential?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representatives of Western University’s Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.</td>
</tr>
</tbody>
</table>

Your demographic survey responses will be collected through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western’s Qualtrics server is in Ireland, where privacy standards are maintained under the European Union safe harbour framework. The data will then be exported from Qualtrics and securely stored on Western University’s server.

Identifiable information such as your Indigenous status, if applicable, will be collected through the demographics questionnaire for the purpose of ensuring the sample is representative of Indigenous and non-Indigenous perspectives. This information will solely be accessed by the research supervisor (principal investigator) and the research staff (Master Student). This information will be de-identified and represented as an overall percentage in the thesis report.

Please note identifying information (i.e. consent forms and master list) is stored separately from the data collected. The master list will be destroyed when data collection is complete and it is no longer required.

The researcher will keep all personal information about you in a secure and confidential location at Western University (ie. With the Principal Investigator) for seven years. During the study and throughout data collection and analysis, a list linking your study number/pseudonym with your name [and other identifiers if applicable, such as contact information] will be kept in a password protected file on the research staff’s OneDrive, separate from your study file. If the results of the study are published, your name will not be used.

Your audio-recordings and verbatim transcripts of the recordings will be kept in the researcher’s secured OneDrive during the study. All files will be kept for seven years with the principal investigator in a secured location at Western University after the study is complete.

Direct and indirect quotes will be de-identified and used in the thesis report and manuscript, where applicable. All quotes, both direct and indirect, by participants will be coded to ‘NS1’: “insert quote”, ‘NS2’: “insert quote”, ‘NS3’: “insert quote”, and so forth. No names will be
used and content within the quotes will be ensured to uphold confidentiality of any and all individuals (names or identifiers of students), organizations (local or known identifiable partners), and institutions (name of schools, hospitals, etc.).

Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of (theoretical) focus groups, if applicable in your case and this study, prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants and not repeat what is said in the focus (theoretical) group to others.

Future Uses:
All identifiable information will be deleted from the dataset collected so that individual participant's anonymity will be protected. The de-identified data will be accessible by the study investigators as well as the broader scientific community. More specifically, the data will be made available to other researchers upon publication so that data may be inspected and analyzed by other researchers. The data that will be shared on the School of Nursing at Western University’s database will not contain any information that can identify you.

How can I receive a copy of the research results?
Dissemination of the research results will ensure anonymity and all responses will be de-identified. Participants may request a copy of the research results and the student researcher will send a copy to the appropriate email address.

Are participants compensated to be in this study?
You will not be compensated for your participation in this research. A broad thank you acknowledgement will be made in the thesis manuscript/publication for all participants in the study. No individual names or identifiers will be mentioned.

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. You do not waive any legal right by consenting to this study.

After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.

We will give you any new information that may affect your decision to stay in the study.

If you are a First Nations or an indigenous person who has contact with spiritual 'Elders', you may want to talk to them before you make a decision about this research study.

Ethics Review
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 (519) 661-3036, 1-844-720-
This research study has been reviewed and approved by [Name of University’s] University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact the Research Ethics Board at [Number to REB at University] or [Email to REB staff].

**Whom do participants contact for questions?**
If you have questions about this research study please contact:

**Principal Investigator:** Dr. Victoria Smye, RN, PhD  
Phone Number: [Removed]  
Email Address: [Removed]

**Master Student:** Ivy Tran, RN, MScN Student  
Phone Number: [Removed]  
Email Address: [Removed]

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

**Written Consent Form**
Please print off and complete the Written Consent form if you are willing to participate. You may scan and email the signed form to the research staff (Master’s Student – Ivy Tran). The completed written consent form will be emailed back to you and a copy kept in a secured file with the research team, separate from the data collected.

Please note there may be a potential loss of anonymity with sending consent forms via email and the research staff will take all precautions to minimize loss, including: viewing email correspondences in a private space, ensure regular password updates, and placing emails in appropriate folders that will intentionally be mislabeled to limit access.
# Written Consent Form

**Canadian Undergraduate Nursing Students’ Experiences of Learning Indigenous Health Content**

<table>
<thead>
<tr>
<th>Letter of Information and Consent – Faculty and/or Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Investigator:</strong></td>
</tr>
<tr>
<td>Dr. Victoria Smye, RN, PhD</td>
</tr>
<tr>
<td>Arthur Labatt Family School of Nursing, Western University</td>
</tr>
<tr>
<td>[Email]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ivy Tran, BScN, RN, MScN Student</td>
</tr>
<tr>
<td>Arthur Labatt Family School of Nursing, Western University</td>
</tr>
<tr>
<td>[Email]</td>
</tr>
</tbody>
</table>

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

### MY CONSENT:

I agree to the following:

- ✓ I have read and understand the information contained in the Information Letter
- ✓ I agree to participate and be audio-recorded in this research
- ✓ I understand the risks and benefits to the study
- ✓ That I am a volunteer and can withdraw from the study at any time and may choose not to answer any question
- ✓ That the data will be securely stored at Western University for a minimum period of 7 years following completion of the research project
- ✓ I understand that the research findings will be made available to me upon request
- ✓ I will remain anonymous in the use of unidentified quotes obtained during the study in the dissemination of this research
- ✓ All of my questions have been answered

<table>
<thead>
<tr>
<th>Print Name of Participant</th>
<th>Signature</th>
<th>Date (DD-MMM-YYYY)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Print Name of Person Obtaining Consent</th>
<th>Signature</th>
<th>Date (DD-MMM-YYYY)</th>
</tr>
</thead>
</table>
Appendix E

Interest to Participate/Eligibility Questionnaire

Qualtrics Survey

1. Please enter your first and last name below.
   
   First Name:
   Last Name:

2. Are you able to read and speak English proficiently?
   
   __ Yes
   __ No

3. Do you identify as Indigenous (ie. First Nations, Inuit, or Métis)?
   
   __ Yes
   __ No
   __ Prefer not to answer

4. If yes, are you status or non-status?
   
   __ Status
   __ Non-status
   __ Prefer not to answer

5. Are you enrolled in the Collaborative/Baccalaureate Nursing Program or Compressed Time Frame Nursing Program?
   
   __ Collaborative Baccalaureate Nursing Program
   __ Compressed-Time Frame Nursing Program (18 months – 2 years)
   __ Not Sure

6. Have you taken a study course specific for Indigenous health?
   
   __ Yes
   __ No
   __ Not Sure

7. Have you taken a nursing course that has course content (ie. One or more lecture(s)/component(s) of the entire course) on Indigenous health?
   
   __ Yes
   __ No
   __ Not Sure
8. What is your email address? Please include an email address you use most frequently and check on a regular basis. By providing this email, you will be contacted via this email for follow up if you are eligible to participate.

   Email:

9. What is the best daytime telephone number to reach you at?

   Daytime Telephone Number:

10. What is the best evening telephone number to reach you at?

    Evening Telephone Number:

11. Please leave any additional information that you would like us to know in the space provided below.

    Additional information:

Thank you for completing this survey. You will be contacted if you are eligible to participate in this study.
Appendix F

Demographic Questionnaire – Qualtrics Survey

Please complete the following preliminary demographics questionnaire.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Please indicate your gender.</td>
</tr>
<tr>
<td></td>
<td>___ Male</td>
</tr>
<tr>
<td></td>
<td>___ Female</td>
</tr>
<tr>
<td></td>
<td>___ Other: _________</td>
</tr>
<tr>
<td>2.</td>
<td>Please select the category that includes your age.</td>
</tr>
<tr>
<td></td>
<td>___ Under 18</td>
</tr>
<tr>
<td></td>
<td>___ 18-21</td>
</tr>
<tr>
<td></td>
<td>___ 22-25</td>
</tr>
<tr>
<td></td>
<td>___ 26-29</td>
</tr>
<tr>
<td></td>
<td>___ 30-33</td>
</tr>
<tr>
<td></td>
<td>___ 34-37</td>
</tr>
<tr>
<td></td>
<td>___ 38 or Above</td>
</tr>
<tr>
<td>3.</td>
<td>Are you enrolled as an international student or domestic student?</td>
</tr>
<tr>
<td></td>
<td>___ International</td>
</tr>
<tr>
<td></td>
<td>___ Domestic</td>
</tr>
<tr>
<td>4.</td>
<td>Please indicate your country of birth</td>
</tr>
<tr>
<td></td>
<td>___ Canada</td>
</tr>
<tr>
<td></td>
<td>___ Other</td>
</tr>
<tr>
<td>5.</td>
<td>a) If born in Canada, do you identify as Indigenous (ie. First Nations, Inuit, or Métis)?</td>
</tr>
<tr>
<td></td>
<td>___ Yes: ____________________</td>
</tr>
<tr>
<td></td>
<td>___ No</td>
</tr>
<tr>
<td></td>
<td>___ Prefer not to answer</td>
</tr>
<tr>
<td>b)</td>
<td>If yes, are you status or non-status?</td>
</tr>
<tr>
<td></td>
<td>___ Status</td>
</tr>
<tr>
<td></td>
<td>___ Non-status</td>
</tr>
<tr>
<td></td>
<td>___ Prefer not to answer</td>
</tr>
<tr>
<td>6.</td>
<td>Do you speak another language other than English at home?</td>
</tr>
<tr>
<td></td>
<td>___ English only</td>
</tr>
<tr>
<td></td>
<td>___ Other than English</td>
</tr>
<tr>
<td>7.</td>
<td>What is the highest level of school you have completed or the highest degree you have achieved?</td>
</tr>
<tr>
<td></td>
<td>___ High school degree or equivalent</td>
</tr>
<tr>
<td></td>
<td>___ Some college but no degree</td>
</tr>
<tr>
<td></td>
<td>___ Bachelor’s degree (e.g. BA, BSc): ______</td>
</tr>
<tr>
<td></td>
<td>___ Master’s degree (e.g. MA, MS, MEd): ______</td>
</tr>
</tbody>
</table>
___ Professional degree (e.g. MD, DDS): _______
___ Doctorate (e.g. PhD, EdD):_______

8. Which of the following categories best describes your employment status?
___ Employed, working 1-15 hours per week
___ Employed, working 15-36 hours per week
___ Employed, working 40 or more hours per week
___ Not employed, looking for work
___ Not employed, NOT looking for work
___ Student
___ Homemaker
___ Self-employed
___ Disabled, not able to work

9. Were you in the Native Nurses Entry Program? If so, what aspects did you find helpful/not helpful?

___ Yes
___ No

What was helpful: 

Not helpful: 

10. Please specify the type of nursing program you are enrolled in:
___ Collaborative/Baccalaureate Nursing Program
___ Compressed-Time Frame Program (18 months – 2 years)
___ Not Sure

11. What year of the program are you in?
___ Year 1
___ Year 2
___ Year 3
___ Year 4

12. Have you taken a study course specific for Indigenous health?
___ Yes
___ No
___ Not Sure

13. If yes, was it a mandatory course or an elective?
___ Mandatory
___ Elective

14. Have you taken a nursing course that has course content on Indigenous health?
___ Yes
___ No
___ Not Sure

Thank you for completing the preliminary questionnaire.
Appendix G

Ethics Approval Western University’s Non-Medical Ethics Review – Delegated

Western Research

Date: 15 August 2019
To: Dr Victoria Sanye
Project ID: 114004

Study Title: Canadian Undergraduate Nursing Students’ Experiences of Learning Indigenous Health Content
Short Title: Undergraduate Nursing Students’ Experiences of Learning Indigenous Health
Application Type: NMREB Initial Application
Review Type: Delegated
Full Board Reporting Date: September 6 2019
Date Approval Issued: 15/Aug/2019
REB Approval Expiry Date: 15/Aug/2020

Dear Dr Victoria Sanye

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

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

Documents Approved:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
<th>Document Date</th>
<th>Document Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debriefing Form</td>
<td>Debriefing document</td>
<td>16 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Demographics Questionnaire</td>
<td>Online Survey</td>
<td>16 Jul/2019</td>
<td>1</td>
</tr>
<tr>
<td>Interview Guide</td>
<td>Interview Guide</td>
<td>12 Jun/2019</td>
<td>1</td>
</tr>
<tr>
<td>Letter of Information and Consent - Student</td>
<td>Written Consent/Assent</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Letter of Information and Consent - Faculty and Instructor</td>
<td>Written Consent/Assent</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Letter of Information and Consent - In Class Observation</td>
<td>Written Consent/Assent</td>
<td>31 Jul/2019</td>
<td>1</td>
</tr>
<tr>
<td>Observation Guide</td>
<td>Non-Participant Observation Guide</td>
<td>16 Jul/2019</td>
<td>1</td>
</tr>
<tr>
<td>Recruitment Emails</td>
<td>Recruitment Materials</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Recruitment Poster - Instructors and Faculty</td>
<td>Recruitment Materials</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Recruitment Poster - Instructors and Faculty 2</td>
<td>Recruitment Materials</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Recruitment Poster - Nursing Students 1</td>
<td>Recruitment Materials</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
<tr>
<td>Recruitment Poster - Nursing Students 2</td>
<td>Recruitment Materials</td>
<td>23 Jul/2019</td>
<td>2</td>
</tr>
</tbody>
</table>

Documents Acknowledged:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
<th>Document Date</th>
<th>Document Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility to Participate in Study Survey</td>
<td>Screening Form/Questionnaire</td>
<td>18 Jul/2019</td>
<td>1</td>
</tr>
</tbody>
</table>

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.
The Western University NMREB 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 NMREB 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 NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

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

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

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

Ivy Tran

ACADEMIC BACKGROUND

Master of Science in Nursing (MScN) 2017 – 2023
Western University, London, Ontario
- Field of Study in Leadership in Health Promotion and Advanced Nursing Practice
- Supervisor: Dr. Victoria Smye
- Committee Member: Dr. Fiona Webster

Degree in Bachelor of Sciences in Nursing (4-Year Collaborative Program) 2013 – 2017
Fanshawe College & Western University, London, Ontario
- Graduated with distinction

PROFESSIONAL EXPERIENCE

Public Health Nurse/Team Lead (Temp Full-Time Contract) Mar 2022 – Current
Middlesex-London Health Unit – London, ON

Registered Nurse – Vaccinator/COVID Assessment Centre (Casual) May 2021 – Mar 2022
London Health Sciences Centre and Middlesex-London Health Unit – London, ON

Public Health Nurse (Permanent Full-Time) Jul 2020 – Feb 2022
Southwestern Public Health – St. Thomas, ON

Public Health and Travel Officer (Casual/Part-Time) Jul 2020 – Jul 2021
Public Health Agency of Canada – Point Edward, Sarnia, ON

Primary Care/New Comer Clinic Nurse Apr 2020 – Dec 2022
London InterCommunity Health Centre – London, ON

Graduate Research Assistant Apr – Aug 2020
Lawson Health Research Institute – London, ON

Community Mental Health Nurse Jan 2019 – Dec 2020
Canadian Mental Health Association - Middlesex, London, ON

Graduate Teaching Assistant – Health Informatics Sep 2017 – Dec 2019
Arthur Labatt Family School of Nursing – Western University, London, ON

Mental Health Worker (Casual) Jul 2017 – Dec 2020
Canadian Mental Health Association – Middlesex, London, ON
SCHOLARSHIPS, ACADEMIC HONOURS, AND AWARDS

The Chica Project Scholarship 2023
Dr. Joan Lesmond Memorial Scholarship 2023
S.E. Health H.O.P.E Scholarship 2022
Western Graduate Student Scholarship 2017-2020
Dean’s Honor List 2014/2015/2017
CNSA National Conference Award Scholarship 2016
Nursing Alumni Class of ‘83 Global Opportunities Award 2015
Kyle Dobrowolski Memorial Nursing Scholarship 2015
Fanshawe Student Union Leadership Award Scholarship 2014
Western Scholarship of Distinction 2013

PROFESSIONAL MEMBERSHIPS

Sigma Honor Society of Nursing – Iota Omicron Chapter Since 2016
- Student Inductee in recognition of academic achievement and leadership potential

Registered Nurses’ Association of Ontario (RNAO) Since 2013
- Interest Groups: Community Health Nurses’ Initiative Group (CHNIG), Mental Health Nursing Interest Group (MHNIG), & Nursing Students of Ontario (NSO) Interest Group (2013-2017)
- Certifications and Training: Breastfeeding, DDD, Addictions and Substance Abuse

Community Health Nurses’ Initiative Group (CHNIG) Since 2013
- Student Affiliate Representative on the Board of Directors 2017 – 2018
- Student Affiliate Sub-committee member on the Board of Directors 2018 – 2019
- Involvement: Teleconferences, networking events, Workshop Planner and Facilitator (Mar 2018)

Canadian Nursing Students’ Association (CNSA) 2013 – 2017
- Ontario-Quebec Regional Conference in Toronto (2016)

PUBLICATIONS


PRESENTATIONS

- CASN – Biennial Canadian Education Research Conference - Poster May 2023
- CASN – Biennial Research Conference - Poster (Cancelled) May 2020
- Legacy 2020: Arthur Labatt Family School of Nursing Research Conference (Cancelled) May 2020
- London Health Research Day 2020 – Poster Presentation (Cancelled) May 2020
- London Health Research Day 2019 – Poster Presentation Apr 2019
- Western Research Forum 2019 – One-Minute Lightning Talk Mar 2019
• Western Research Forum 2019 – Poster Presentation  Mar 2019
• Avenues of Nursing – Guest Speaker on Community Mental Health Nursing  Mar 2019
• London Region Advanced Practice Nurses Annual Dinner – HealthChat Initiative  Nov 2017