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Article 5

File of Uncertainties: Exploring student experience of applying decolonizing knowledge in practice

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File of Uncertainties: Exploring student experience of applying decolonizing knowledge in practice

Cover Page Footnote

We acknowledge the Coast Salish peoples of the Songhees, Esquimalt, and W̱SÁNEĆ, Cowichan and Stzuminus communities on whose unceded and occupied territories we pursue our education and livelihood. We acknowledge that we are the beneficiaries of colonizing policies that have displaced local Indigenous communities from their traditional territories and systematically privileged European settlers. As members of the nursing profession, we endeavour to conduct ourselves in ways that respect Indigenous Peoples and to take actions that redress Indigenous-specific racism, injustice, and inequities in healthcare. Leanne Kelly; I am highly aware of my privilege of being an educated and socioeconomically advantaged cis-gendered Métis-Cree woman originally from the Qu'appelle Valley in Saskatchewan. I recognize that my relocation to unceded and occupied Coast Salish territory comes with responsibilities to know my role in giving voice and holding space for my colleagues and friends of this land. To this end as a visibly Indigenous nurse educator, I am committed to interrogating oppressive systems. Christina Chakanyuka; I am a Métis cis-gender nurse, educator, and (re)searcher from the Northwest Territories who had the privilege of being raised on the traditional homelands of my matrilineal Dene and Métis-Cree relatives. I hold strong family ties to my mother's Indigenous and British relations as well as my father's Scottish-Canadian, 9th generation settler relations. I care deeply about advancing anti-racism praxis in nursing and affirming the rights of Indigenous Peoples to self-determination in healing and wellness. Tamarah Braithwaite; I identify as a cis-gender female white settler. I am a first and third generation visitor to these lands and am of English, Irish, Scottish, and Welsh descent. I was born on the lands of the Lhtako Dene Nation and have been a visitor on Coast Salish lands since 1993. I identify my position as a visitor here and acknowledge with respect the Lekwungen-speaking Peoples on whose lands I have had the honour to seek education. These traditional unceded lands are shadowed by a colonial past and present and I express my profound appreciation at the opportunity as a white settler to participate in this research as an Indigenous ally and to continue to visit on these lands. We acknowledge with gratitude the BC Campus Research Fellows Grant and the Jamie Cassels Undergraduate Research Award for providing funding for this project. | Remerciements : Nous reconnaissons les Peuples Salish de la côte des communautés Songhees, Esquimalt et W̱SÁNEĆ, Cowichan et Stz'uminus sur les territoires non cédés et occupés sur lesquels nous poursuivons notre formation et nos moyens d'existence. Nous reconnaissons que nous sommes les bénéficiaires des politiques de colonisation qui ont déplacé les communautés autochtones locales de leurs territoires traditionnels et systématiquement privilégié les colons européens. En tant que membres de la profession infirmière, nous nous efforçons de nous conduire d'une manière qui respecte les Peuples Autochtones et de prendre des mesures qui corrigent le racisme, l'injustice et les inégalités propres aux Autochtones en matière de soins de santé. Leanne Kelly : Je suis très consciente de mon privilège d'être une femme Métis-Cree instruite et socioéconomiquement favorisée, originaire de la vallée de Qu'Appelle en Saskatchewan. Je reconnais que ma réinstallation sur le territoire non cédé et occupé des Salish de la côte implique la responsabilité de connaître mon rôle en donnant la parole et en gardant de l'espace pour mes collègues et amis de cette terre. À cette fin, en tant qu'infirmière enseignante visiblement Autochtone, je m'engage à remettre en question les systèmes oppressifs. Christina Chakanyuka : Je suis une Métis cisgenre, infirmière, enseignante et chercheuse des Territoires du Nord-Ouest qui a eu le privilège d'être élevée sur les terres traditionnelles de mes parents matrilinéaires Dene and Métis-Cree. J'entretiens des liens familiaux solides avec les parents autochtones et britanniques de ma mère ainsi qu'avec les parents canadiens-écossais, colons de neuvième génération, de mon père. Je me soucie profondément de faire progresser la pratique antiraciste dans les soins infirmiers et d'affirmer les droits des Peuples Autochtones à l'autodétermination en matière de guérison et de bien-être. Tamara Braithwaite : Je m'identifie comme une femme cisgenre blanche et visiteuse de première et troisième génération sur ces terres et je suis d'origine anglaise, irlandaise, écossaise et galloise. Je suis née sur les terres de la Nation Lhtako Dene et je visite les terres des Salish de la côte

depuis 1993. J’identifie ma position en tant que visiteuse ici et reconnais avec respect les Peuples de langue lekwungen sur les terres desquels j’ai eu l’honneur de poursuivre ma formation. Ces terres traditionnelles non cédées sont assombries par un passé et un présent coloniaux, et j’exprime ma profonde gratitude pour la possibilité, en tant que colon blanc et alliée autochtone, de participer à cette recherche et de continuer à visiter ces terres. Nous reconnaissons avec gratitude la subvention BC Campus Research Fellows Grant et le prix Jamie Cassels Undergraduate Research Award pour avoir financé ce projet.

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File of Uncertainties

Exploring nursing student experience of applying decolonizing and anti-racism knowledge into practice

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Abstract

It is critical that nurse education programs in Canada respond to the Truth and Reconciliation Commission's call to develop a course about the documented impacts of Indigenous-specific racism on the health outcomes of Indigenous people. Initiatives such as San'yas Anti-racism Indigenous Cultural Safety Education, courses on trauma-informed care, and required Indigenous health and history classes in nursing programs are providing a solid beginning. However, the effectiveness of this education requires interrogation. The assumption that education results in changes in nursing practice behavior or uptake of critical knowledge may not be completely accurate in complex environments. To this end, this mixed methods study aimed to explore nursing student experience with incorporating decolonizing and antiracist knowledge into nursing practice with Indigenous patients/clients. Fourth-year baccalaureate program nursing students at a Canadian university who had completed a core course on the impacts of colonization and Indigenous-specific racism on Indigenous health in Canada were surveyed regarding their experience of applying this knowledge during their clinical rotations. Sixteen participants responded to an anonymous online survey consisting of three short-answer open-ended questions and six Likert-style questions about their experiences. The emergent narrative themes and Likert-scale data indicate that although the students valued the information provided in the class, they continued to experience some uncertainty when caring for Indigenous clients. Prominent areas of uncertainty included applying knowledge to practice, student confidence in disrupting racist treatment of Indigenous patients by their healthcare colleagues, and knowing how to approach sensitive client situations to avoid re-traumatization. This article discusses these student responses and implications for nursing education and future research.

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Keywords: Indigenous health; cultural safety; antiracism; nurse education; healthcare curriculum

Acknowledgements and Positionality

We acknowledge the Coast Salish peoples of the Songhees, Esquimalt, and W̱SÁNEĆ, Cowichan and Stzuminus communities on whose unceded and occupied territories we pursue our education and livelihood. We acknowledge that we are the beneficiaries of colonizing policies that have displaced local Indigenous communities from their traditional territories and systematically privileged European settlers. As members of the nursing profession, we endeavour to conduct ourselves in ways that respect Indigenous Peoples and to take actions that redress Indigenous-specific racism, injustice, and inequities in healthcare. To critically locate ourselves within the context of this work, each author has provided a brief positionality statement.

Tamarah Braithwaite; I identify as a cis-gender female white settler. I am a first and third generation visitor to these lands and am of English, Irish, Scottish, and Welsh descent. I was born on the lands of the Lhtako Dene Nation and have been a visitor on Coast Salish lands since 1993. I identify my position as a visitor here and acknowledge with respect the Lekwungen-speaking Peoples on whose lands I have had the honour to seek education. These traditional unceded lands are shadowed by a colonial past and present and I express my profound appreciation at the opportunity as a white settler to participate in this research as an Indigenous ally and to continue to visit on these lands.

Leanne Poitras Kelly; I am highly aware of my privilege of being an educated and socioeconomically advantaged cis-gendered Métis-Cree woman originally from the Qu'appelle Valley in Saskatchewan. I recognize that my relocation to unceded and occupied Coast Salish

territory comes with responsibilities to know my role in giving voice and holding space for my colleagues and friends of this land. To this end as a visibly Indigenous nurse educator, I am committed to interrogating oppressive systems.

Christina Chakanyuka; I am a cis-gender mother of three originally from the community of Fort Smith, Northwest Territories with strong family ties to my Mother's British, Dene, and Cree-Métis relations as well as my Father's 9th generation Scottish-Canadian settler relations. As a Métis nurse educator occupying space on Coast Salish homelands, I consider it my responsibility to walk softly on this land, listen to and learn from local Knowledge Holders, and engage in every-day actions that uphold local Indigenous Peoples' rights to self-determination.

Author Relationships

The decision to write together was born out of an opportunity to be co-learners in a small research project. The Jamie Cassels Undergraduate Research Award, (JCURA) provides funds to support undergraduate students in research projects that develop knowledge and research skills. At the time of this project inception, Tamarah Braithwaite was a fourth year undergraduate student with a strong interest in equity and anti-racism. At the time of publication, Tamarah is now an RN working fulltime in acute care. Both Leanne Kelly and Christina Chakanyuka are faculty at the University of Victoria, PhD candidates and novice researchers. The PI for this project was Leanne Kelly, however throughout our data collection, analysis and writing process, close communication and collaborative effort between Leanne and Tamarah has been consistent and transparent. Christina Chakanyuka provided early project development support, analysis feedback and editing support. Our collaborative analysis work reflected insights and discussion from our respective Indigenous and white settler positions.

FILE OF UNCERTAINTIES

Method selection

The authors purposefully chose a western academic method of a survey to gather data based on convenience, novice researcher experience, ease of implementation, minimal infringement on student time and to fit within the digital strategies used during the pandemic. This project provided an opportunity for our team to learn together, with straightforward methods that could provide opportunity to work through the research process. The authors acknowledge that there are other ways to conduct research that challenge western linear processes, however for this small initial project intentional choices were made to utilize tools that would support our team learning in this way.

We acknowledge with gratitude the BC Campus Research Fellows Grant and the Jamie Cassels Undergraduate Research Award for providing funding for this project.

Introduction

In 2015 the Truth and Reconciliation Commission of Canada set out 94 Calls to Action to improve the well-being of Indigenous people. Two focus areas of the calls were education and healthcare, with a specific call (#24) to improve cultural safety training in nursing and medical programs at Canadian universities (TRC, 2015). Specifically, Indigenous focused "skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism." (TRC, 2015, p.3) A recent environmental scan of 107 schools of nursing and midwifery in Canada (Metheny & Dion Fletcher, 2021) examined the incorporation of cultural safety content into their programs since the TRC Calls to Action were released. The scan found that less than one-fifth of these schools had publicly displayed evidence on their school websites that indicated they met the criteria. Given the imperative to respond to the ongoing documentation of the impacts of racism on health outcomes, it is critical that nursing education programs develop content in this area and make clear how they are accountable and meeting the goals laid out by the TRC Calls to Action (Allan & Smylie, 2015; Gaudry, 2016; TRC, 2015; Ward, Ninomiya, & Firestone, 2021).

In response to TRC Call 24, the Canadian university where this research occurred, designed a course – Understanding Indigenous Health and Wellness – that examines the legacy and impacts of colonization and Indigenous-specific racism on Indigenous health and wellness in Canada. The course seeks to support nursing students to utilize a decolonizing lens to develop culturally safe practice. This project, entitled, the *Files of Uncertainties,* builds on the writings of Susan Dion, (2007) Indigenous scholar from York University where she describes the concept of the 'perfect stranger' (p. 330) in relation to the void that often exists between Indigenous communities and settler communities. Dion invites her students to create a file of (un)certainties (p. 334) which positions self-interrogation juxtaposed with Indigenous tropes and learnings at the

center of exploration. Our project was created to invite fourth year nursing students to explore their own experiences of applying decolonizing knowledge learned in the Indigenous wellness course to their practice. This exploration was positioned within the title of 'uncertainty' to acknowledge the gaps that exist among non-Indigenous peoples' relationship to Indigenous peoples. As educators we recognize the complex nature of the intersecting influences of colonization, racism, health care systems, personal positionality, and their influence on nursing praxis. This project provided an opportunity for nursing students to name and reflect on these complexities within a safe and anonymous space and to invite reflection on their work to incorporate decolonizing knowledge into their nursing practice with Indigenous clients.

This paper provides some background and context regarding the need for cultural safety education to be better understood and to substantiate why we developed the Files of Uncertainties research project. We outline our research questions, data collection, and analysis methods. Emergent themes are presented using illustrative exemplars from participants' narratives. We then discuss the study's implications and identify areas for future research.

Background

The concept of cultural safety was developed in the 1980s by Māori nurse Irihapeti Ramsden to address Indigenous-specific racism in healthcare and improve the health and well-being of Indigenous people (Ramsden, 2002; Ward, Fridkin, & Fridkin, 2016). Despite broad usage of this term within scholarly literature, health equity research around the world provides contemporary evidence that Indigenous people continue to experience poorer health outcomes. They continue to have less access and less satisfaction with healthcare encounters due to trauma caused by colonialism, systemic oppression, and ongoing racism (Sherwood, 2013; Sherwood & Edwards, 2006; Ward, Fridkin, & Fridkin, 2016; Ward, Ninomiya, & Firestone, 2021).

While initiatives to incorporate cultural competence and cultural safety education have gained some traction within nursing over the years, (Papps, 2005; Rowan et al, 2013) evidence of Indigenous-specific racism and oppression under dominant white ideologies remains (Green, 2016; Turpel-Lafond, 2020; Ward, Ninomiya, & Firestone, 2021). High-profile reports of Indigenous fatalities due to racism in healthcare continue to surface in Canada. For example, less than five years after *Out of Sight* documented the death of Brian Sinclair in a Manitoba emergency waiting room (Brian Sinclair Working Group, 2017), a video of the clinician-delivered racist abuse of Joyce Echaquan in a Quebec hospital hours before her death went viral via social media (Shingler, 2020). In British Columbia, the 2020 report *In Plain Sight* captured personal experiences with racism reported by almost 9,000 respondents and clearly demonstrated the impacts of persistent Indigenous-specific racism in our healthcare system (Turpel-Lafond, 2020). Given this evidence, there is an urgent need to change healthcare practice, policy, and education to address systemic racism and advance reconciliation through the creation of partnerships with Indigenous peoples that uphold Indigenous rights to self-determination (Green, 2016; Sherwood & Edwards, 2006; TRC, 2015; Ward, Fridkin, & Fridkin, 2016; Ward, Ninomiya, & Firestone, 2021). However, the incidence of racism within the healthcare system speaks to the complexity of transforming knowledge into practice. As each new cohort of nursing students graduate and begin applying their knowledge, it is imperative that we ensure the issues of racism and decolonizing actions be well-understood and taken up in practical ways.

The academic institution has historically been a hegemonic space that upholds Western knowledge systems and patriarchy, thus perpetuating colonialism, oppression, and racism towards those who exist in spaces of difference (Gaudry, 2016; Green, 2016; Metheny & Dion Fletcher, 2021; Turpel-Lafond, 2020). Without intentional exploration of the role of nursing

education in disrupting oppressive systems we posit that nurses will continue to participate in established systems of patriarchy and racism. The critical theory movement asserts that philosophy and social science should "work to free people from political and other forms of oppression" (Dahnke & Dreher, 2016, p. 403). Thus it is our assertion that until nurses are educated to interrogate Western knowledge systems and participate in decolonizing education and practice, Indigenous peoples will continue to experience racialized interactions that negatively impact health outcomes, community development, self-determination, and cultural expression (Green, 2016; McGibbon et al., 2014; Sherwood, 2013; Sherwood & Edwards, 2006; Smith, 2012; Vukic et al., 2012; Ward, Fridkin, & Fridkin, 2016; Ward, Ninomiya, & Firestone, 2021).

The Files of Uncertainties Project

Purpose

The purpose of this mixed method study was to provide an opportunity within a safe and anonymous space for nursing students to explore their own confidence and potential feelings of uncertainty while applying decolonizing knowledge to their nursing clinical practice regarding interactions with Indigenous clients. Students were asked to explore and describe their own experience, both successes and challenges, of integrating knowledge into practice. This information would ultimately be valuable in ongoing development of nursing curriculum. This project was approved by the Human Research Ethics Board through the Research Administration Information System at the Canadian university where the research took place.

Method and Data Collection

This study used a western academic framework consisting of convergent mixed method anonymous online survey with three open-ended short-answer questions and six Likert-scale questions, with an estimated time commitment of 30–60 minutes per participant. Participation in the survey was voluntary and anonymous. The study engaged fourth-year nursing students at a Canadian university who had completed the 1.5 credit 13-week course titled Understanding Indigenous Health and Wellness. Students who had completed the Understanding Indigenous Health and Wellness course and their subsequent Spring clinical practice were invited to participate in the study. An email was distributed through the university's School of Nursing communications to this cohort of 150 senior undergraduate nursing students. No specific demographic information was collected on the identity of the students. Interested student participants were able to follow an internet hyperlink in the nursing school communications email to locate the survey. The participating students were able to contact the third-party administrative assistant who did not teach in the course to discuss consent, information gathering, and study data protection processes. The third-party administrative assistant collected the data electronically via online survey. All participants were provided with a twenty-dollar gift card as compensation for their time, arranged through the neutral third-party administrative assistant to maintain anonymity.

Consent

All information regarding the project was provided in the Letter of Information sent to the participants. Potential participants were provided with an anonymous opportunity to ask questions prior to agreeing to participate. The letter of information included details related to implied consent. A specific statement of implied consent was built into the survey and was required to be checked prior to opening the survey for completion. Data were stored

electronically in encrypted files on a password-protected server accessed by the neutral third-party administrative assistant and shared securely with the researchers once all identifiers were removed.

Research Questions & Survey Development

The survey questions were developed through discussion between two of the Indigenous nurse faculty who have been instructors of this material for over 15 years and who have worked within Indigenous communities for the bulk of their nursing careers. The survey tool was used to create an anonymous space for students to reflect and feel unencumbered to explore and voice the uncertainties that exist within the juxtaposed space of Indigeneity, racism, and nursing practice. The questions were posed to allow student exploration of their experience and to name potential discomfort, tensions, and successes without the influence of grading implications or instructor judgment.

The informal survey consists of two types of questions: three open-ended and six Likert style. The open-ended questions were selected to encourage students to draw from their practice experience and reflect on situations that they had encountered. The Likert scale questions were created based on past nursing instructors' conversations with students and anonymous student course evaluation comments. They were not pre-tested but were reflective of Understanding Indigenous Health and Wellness course concepts.

Open-ended questions:

(1) Think of a scenario in which you (in the role of student nurse) were involved in or observed the care of an Indigenous client within the clinical setting from your Consolidated Practice.
(2) What knowledge, skills, awareness, or personal positionality guided or supported your engagement?
(3) What questions, tensions, or uncertainties created challenges or hesitation for you in your work?

Six questions on a five-point Likert-scale ranging from strongly disagree (1), disagree (2), neutral, (3) agree (4), and strongly agree (5) were also asked:

(1) As a result of taking Indigenous Health and Wellness, I now feel I have sufficient knowledge of the history of Indigenous-settler relations in Canada to inform my nursing practice.
(2) I fully understand the difference between a culturally responsive approach and an antiracist approach to my nursing interactions with Indigenous people.
(3) I feel personal tension or uncertainty when preparing to interact with Indigenous patients/clients in the healthcare system. (R)
(4) I feel personal tension or uncertainty when interacting with Indigenous people outside the healthcare system. (R)
(5) I know how to intervene when I observe or experience racial tensions between Indigenous people and healthcare workers.
(6) White/settler privilege is a concept that I am uncertain about in my personal role in society and my professional practice. (R)

Data Analysis

Data from the completed surveys were initially reviewed by the neutral administrative assistant who was not associated with the School of Nursing and who signed a non-disclosure form. They removed all identifying information and securely forwarded the cleaned and password-protected data to the research team for analysis. Two types of data were collected: Qualitative narrative and quantitative Likert scale survey data (De Leon & Chough, 2013; Thorne, 2000). The qualitative, narrative analysis was used to examine each student's answers to the open-ended questions. Constant comparative analysis was used to analyze responses across the participants and generate and consolidate themes in the narrative responses (Smith, 2012; Thorne, 2000). The quantitative survey data had a 5-point Likert scale and scores were reported in frequencies. The results were used to compare and contrast the themes emerging from the narratives and assist in contextualizing students' perceptions of their own competency with the course knowledge (McBurney & White, 2007).

Results

Qualitative Data: Narrative Themes

Sixteen of the 150 senior undergraduate nursing students responded representing a 10.6% response rate. The 16 nursing student participants provided narrative descriptions of their experiences working with Indigenous patients/clients and completed the survey online anonymously. Eight themes arose from the narratives: (1) mistrust in the healthcare system and trauma, (2) uncertainty and tension, (3) stereotyping and racism, (4) community and healing supports, (5) power differentials, (6) systems and policy, (7) resource scarcity, and (8) applying the Indigenous-focused course content to practice. Although we created eight separate themes there is obvious overlap in their creation. For example, power differentials were spoken about in relation to undergraduate student perception of their own power and ability to disrupt but were also influenced by the hierarchal system and policies of institutions that place undergraduate students in a position of lesser power and autonomy.

Mistrust in the Healthcare System and Trauma

All but one of the 16 students articulated their awareness of the impacts of historical inequities on Indigenous people's contemporary relationships with the health system. Students voiced concerns regarding the potential for mistrust of the healthcare system developing out of harm to Indigenous patients/clients as a result of Indigenous-specific racism and stereotyping as well as intergenerational and/or historical trauma associated with colonization and residential schools. Students identified the importance of using a trauma-informed care approach to engagement with Indigenous patients/clients. Several of the students noted that past inequitable treatment has led Indigenous people to mistrust the healthcare system, which could make them reluctant to share sensitive information (e.g., an inability to read a consent form). The students

explored their perception of broad issues such as institutional neglect in residential schools and Indian hospitals and the potential for re-traumatization in current settings related to power differentials. One student described a client who had identified their past addiction issues and voiced their reluctance to accept fentanyl prior to a procedure. The student observed staff interactions with the client and felt coercion had been present as staff struggled to convince the patient to consent to narcotic use.

> *…when he went down for his angiogram procedure he was told he would be receiving fentanyl prior to the procedure and did not want it done for fear of becoming addicted to fentanyl…I remember one health care provider trying to persuade him into taking fentanyl and getting the procedure done.* (Student participant 8)

> *I knew that Indigenous clients are already in a vulnerable position when they access healthcare due to past histories and trauma associated with the healthcare system and Indigenous individuals.* (Student participant 8)

Uncertainty and Tension

Thirteen of the 16 (81.25%) participants acknowledged feeling uncertainty or tension while working with Indigenous patients. Some participants spoke of uncertainty for themselves directly as they did not know what questions to ask Indigenous patients, while other participants spoke of uncertainty and tension from "being in the middle" between Indigenous clients and senior colleagues uttering racist remarks. One of the students said they would have liked earlier training in navigating situations of conflict involving Indigenous patients. Four other students noted they felt ill equipped to deal with situations involving cultural tension during interactions with Indigenous patients and staff members. These responses referred to not having the necessary toolkit early enough in nursing school, not knowing how to ask sensitive questions appropriately, and not knowing how to respond when an Indigenous patient shared traumatic details of experiences. One of the students related a story in which they felt tension when an Indigenous patient began speaking negatively of other nurses by whom she felt poorly treated.

One student also mentioned feeling cultural tension because nursing school "shoved Indigenous knowledge into us" while not providing enough teaching on cultural diversity and transgender or 2-spirit individuals.

> *I felt awkward and like I wanted to be able to help more, but I didn't know how to. Then I questioned that, and thought that providing safe, culturally competent care is one of the most important things I could do. I find it really challenging after learning in so many classes about Indigenous history and challenges in healthcare, then when I go in these situations I almost always feel like something I am doing is wrong. . . . The more I learn, the more I feel like I am doing something wrong, like nothing I could do would be right.* (Student participant 15)

Responses to the Likert questions further indicated that 37.5% (n=6) of the students "somewhat or strongly" agreed that they felt personal tension or uncertainty while interacting with Indigenous people inside the healthcare system, as compared to 17.75% (n=2.8) outside the healthcare system.

Stereotyping and Racism

Eleven of 16 students (69%) reported witnessing stereotyping, racist comments, biased hospital policies, or tension related to culture and ethnicity. One student described her own feelings of bias due to "subconscious prejudice" which created racial tension. The student acknowledged that these thoughts and opinions must be addressed and worked through when providing care for Indigenous patients. On the Likert-scale questions, when asked if they understood the difference between a *culturally responsive* approach (which predominantly considers cultural difference as the reasons for problematic issues) and an *antiracist* approach (which considers systemic influences and requires disruption of status quo settler privilege), 81.25% (n=13) of participants stated they somewhat or strongly agreed they had this knowledge. This result aligns with their responses regarding white privilege, where 81.25% (n=13) of participants either somewhat or strongly disagreed that they felt uncertain about their personal

and professional role related to this concept. Responses indicate that participants believe they understand the foundational concepts that influence racialized interactions but only one participant's narrative specifically mentioned an acknowledgement of their privilege directly.

Student narratives also included examples of nurses and other healthcare staff describing Indigenous patients negatively while alluding to their racial identity. These examples predominantly included generalizations around alcoholism and drug-seeking behaviour or ascribing particular behaviours to a whole population. Also noteworthy was the mention of four specific examples of stereotyping on a single unit.

> *I have heard unit nurses mention Indigenous clients with comments such as "this is how it is with them". . . It made me feel gross to hear nurses talking about the client in this way.* (Student participant 16)

> *During this time, I experienced an Indigenous woman admitted for a scheduled procedure. This woman was scared and had the support of her husband at the bedside. I witnessed disgusting actions from the nursing staff when it was brought to their attention that the woman had lice.* (Student participant 2)

Community and Healing Supports

Nine of the 16 (56%) student participants referred to the value of community and cultural practices in the health and well-being of Indigenous patients. Multiple students acknowledged the importance of sitting with a patient, hearing them, crying with them, and being present when family and community members were unable to be present. One student felt curious and confident enough to ask a patient about the traditional meaning behind a smudge stick and reflected on utilizing trauma informed skills and approaches to care.

> *I noticed the patient had a smudge stick resting over their lungs and I asked the patient what the importance of this was to them and their care. The patient told me how it assisted with healing when placed on what body part needed assistance to healing. Learning about how to have a trauma-informed approach to caring assisted me in this situation. I did this by having the patient the expert of their history and religion and coming from a cultural humility approach.* (Student participant 9)

Another student expressed uncertainty about the risks for re-traumatization when asking questions about culture-specific supports.

> *I was hesitant to ask about her culture and beliefs, but I would have liked to know looking back because it may have improved her care and assisted her with any other spiritual or other health needs.* (Student participant 3)

Students recognized the importance of family and community support and recognized the strengths that clients may have present in these connections.

> *Their community itself is strong and is something to learn from as it creates strong health and well-being.* (Student participant 3)

> *Involving family in care was also extremely beneficial as their culture is family focused and they could speak to the patient in a language they understood.* (Student participant 12)

Some students had the opportunity to engage in clinical practicum placements with Indigenous partners. One student described how much more culturally safe a placement in northern Canada was compared to those in southern BC.

> *Permanent changes had been made to care delivery methods to ensure culturally safe care was provided. They had a large team of Indigenous nurses / social workers / counsellors, etc., to ensure Indigenous clients felt safe and supported in their healthcare experiences.* (Student participant 4)

Power Differentials

From the narratives, almost half, or seven of the 16 students referred to systemic power differentials that impacted Indigenous patients' sense of power and reported that they had observed situations where Indigenous patients felt afraid to voice concerns to their physicians. These students highlighted their own lack of voice and sense of disempowerment on the unit, which resulted in reluctance to speak up when senior colleagues made derogatory remarks.

> *As a student nurse, the power differentials between RNs, students, physicians, and patients can make it difficult to speak out when we witness something that doesn't align with our values and knowledge.* (Student participant 5)

> *I felt torn as I was a student and the idea of correcting a group of nurses seemed frightening.* (Student participant 16)

> *Another thing that I struggle with is that I can only control my behaviour, I have no control over how other care providers or interdisciplinary team members behave or conduct themselves in practice or how other people's behaviour may impact a client's care experience*. (Student Participant 4)

When asked if they know how to intervene when they observe racialized interactions between healthcare workers and Indigenous patients, 81.25% (n=13) somewhat or strongly agreed. Alternately, 18.75% (n=3) said they were "neutral" or somewhat disagreed. This result suggests that most of the students assess themselves as knowledgeable about intervening in racialized interactions; however, within the narratives, several comments indicated uncertainty that influenced the students' ability to take action.

Systems and Policy

Six of the 16 participants described standard or usual processes within the healthcare setting that reflected agency policy that did not align with Indigenous supports. One of the students related their experience of moral tension between *"the policies that guide us and protect us as nurses versus the security and safety of clients"* when describing the need for frequent safety checks for a patient who may have benefitted from a less traumatic invasion of her space and privacy. Another student commented on how new COVID-19 policies regarding visitation limits family and community engagement. One student described the negative impact of a policy that disallowed keeping traditional food in the unit fridge, thus limiting a patient's access to it.

> *I felt very trapped by this policy and felt it was not fair to deny this patient of this right to comfort and security in the form of cultural healing.* (Student participant 11)

Resource Availability

Three of the 16 students referred to access to appropriate resources. Examples included the Aboriginal liaison nurse being completely booked and unable to see a patient, the student's,

or a patient's lack of knowledge about what resources are available, and a lack of access to important medications such as insulin for some patients who live on reserves.

> *He said he hadn't been taking care of his sugars and seemed afraid of judgment because of this. He said it was hard to purchase insulin on the reserve.* (Student participant 7)

> *There are internal/external resources available if patients request them, but they're spread thin and are not always available or timely.* (Student participant 4)

In contrast, two students noted having appropriate access to resources and the ability to provide patients with booklets and supportive referrals.

Applying the Indigenous-Focused Content to Practice

All 16 participants related some component of theory education and knowledge of equity issues and social determinants of health in their applied practice with Indigenous patients. For example, some students included practical approaches to wound dressings, or pain / pain control and how pain is experienced individually and can differ across cultures. For others, it was specific learning regarding relational practice, or reflexive practice work in the midst of complexity. Students spoke of the cultural sensitivity ladder, (Papps, 2005) development of self-awareness, and acknowledgement of positionality and racial identity. Understanding of intergenerational trauma and use of a trauma-informed care approach came up frequently throughout the narratives: 13 participants (81%) mentioned the importance of knowledge around use of a trauma-informed lens, impacts of intergenerational trauma, trauma experienced during healthcare interactions, or ways to establish and respect boundaries to avoid re-traumatization. Student participants acknowledged that throughout nursing school they have developed a working knowledge and ability to understand and apply core concepts such as privilege, healthcare inequity, racial identity, and power. They also articulated the importance of understanding their own positions in the world in relation to Indigenous clients they may be

working with. Several students also mentioned in their narratives that nursing classes had supplied them with valuable communication techniques such as models for reflection, the value of silence, active listening, and how to simply be present with a client.

Summary of Qualitative Data

The narrative submissions from students were organized into the overlapping themes described. Overall, students were willing to explore challenging situations in their practice and identified overarching influences which illustrate their experiences. Students had knowledge of the potential for Indigenous client mistrust in the health care system related to past traumatic encounters and legacies of colonization. Students provided evidence of racism and stereotyping among their peers and by clinicians within the health system but did not deeply explore their own role in this aspect of care. Students also identified systems-level challenges such as inability to access client community supports, the scarcity of resources available, and the institutional policies that influence their work on the front lines of healthcare. At times, students' comments conveyed a sense of uncertainty when encountering power differentials and a heightened awareness of the unintended consequences of disrupting colleagues they deemed culturally unsafe. Students relied on their knowledge of relational practice, reflexive learning, anti-racist and critical thinking to assist in applying their knowledge to practice but described experiences where they were not always able to act in ways that yielded a shift towards a culturally safe situation. It is unclear if students lacked confidence in their ability to disrupt racialized situations or felt that external situations were too difficult to navigate independently.

Quantitative (Likert Scale) Data Summary

The Likert scale questions were intended to capture student assessment of their own learning and understanding of course content and their ability to apply their knowledge to

practice. The questions were based on content that is currently offered in the Indigenous wellness course. Overall student responses indicate a high degree of understanding of course concepts (see Figure 1 & 2). Results also indicated that there is some uncertainty with applying the knowledge in interactions with Indigenous peoples in the health care system as described in the narrative themes.

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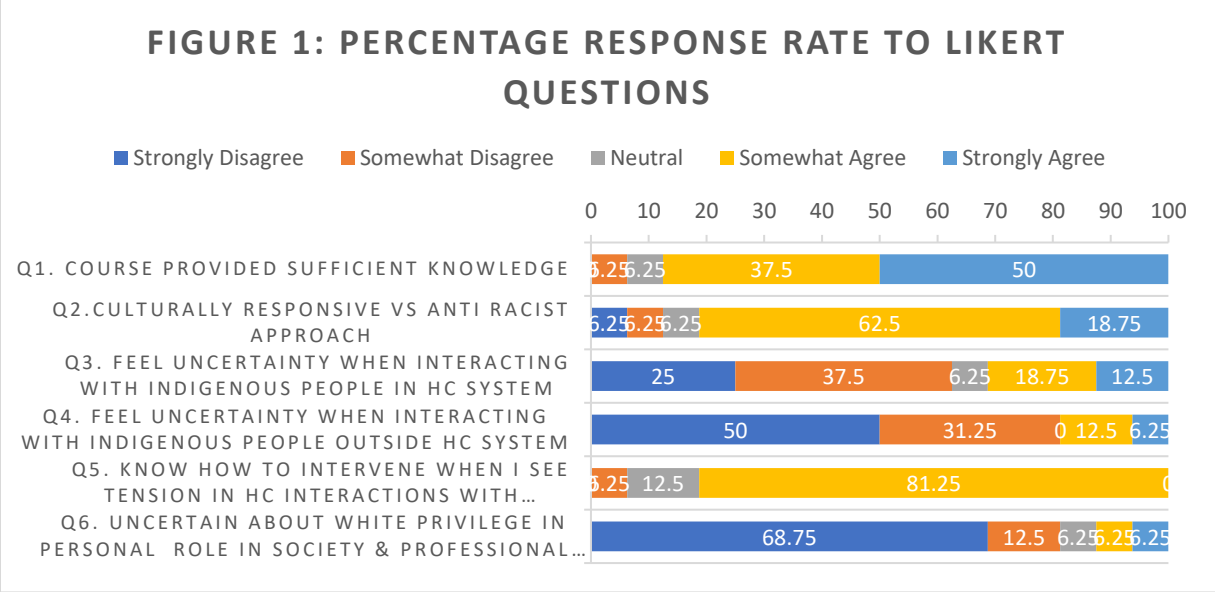

Figure 2

Q1. 87% of respondents feel strongly or somewhat strongly that they have sufficient knowledge of Indigenous-Settler relations.

Q2. 81% report understanding the differences between a culturally responsive vs anti-racist approach to interactions with Indigenous people. This was not clearly demonstrated in the narratives however.

Q3. 62% strongly or somewhat *disagree* that they feel uncertainty *within* health care system interactions with Indigenous people, which indicates that 37% do feel some degree of uncertainty.

Q4. 81% showed strong disagreement to feelings of uncertainty *outside* the health care system.

Q5. 81% somewhat agree that they know how to intervene to disrupt racial tension and 18% indicate neutrality or uncertainty and no respondents indicate strong agreement.

Q6. 81% strongly or somewhat strongly *disagree* that they feel uncertainty with their understanding of white privilege as it applies to their personal role and professional practice. This suggests that students generally feel they have knowledge and understanding of the concepts important to decolonizing and equity.

Discussion

Experiences with Complex and Racialized Health Encounters

We know that globally, Indigenous Peoples continue to face concentric, ongoing trauma associated with the lasting impacts of colonial violence and racism. Notwithstanding the core values of equity and justice embraced as central to the discipline of nursing and despite years of cultural safety and anti-racism training, Indigenous people in Canada still experience Indigenous-specific racism and harm when accessing health services today (McGibbon, 2019; Richardson & Murphy, 2018; Turpel-Lafond, 2020).

Nursing students describe their challenges to the use of anti-racist knowledge include present-day biases of their healthcare provider colleagues, supervisors and agencies. Evidence shows that Indigenous-specific systemic racism contributes to trauma when accessing healthcare services. (Sherwood & Edwards, 2006; Turpel-Lafond, 2021; Ward, Fridkin, & Fridkin, 2016; Ward, Ninomiya, & Firestone, 2021). Almost 70% of the student participants in this study noted some form of racism, mistreatment, or derogatory comments made by hospital staff which diminished the quality of care received by Indigenous patients. Their reflections support the assertion made by other researchers that state work is still required to reduce harmful racialized health interactions in Canadian healthcare facilities and reduce race-related health disparities (Hassen et al., 2021; Phillips-Beck et al., 2020; Turpel-Lafond, 2021; Stout, 2021; Wylie, 2019). Most students also agreed that they had the knowledge regarding how to intervene disrupting racial tensions but the narrative descriptions of their clinical experience illustrated examples in which they felt powerless to actually intervene.

Student narratives provide examples of ongoing tensions such as the difficulty in accessing diabetes medication, agency policies that deny patients traditional food sources, and

denigrating attitudes towards patients with complex personal circumstances demonstrate ongoing issues relating to equity and respectful engagement. Students made comments such as *"I felt awkward," "I felt gross,"* or *"I felt trapped"* in relation to not being able to provide the most culturally safe care. Student responses to two of the Likert-style questions indicate a difference in how students perceive their interactions with Indigenous people inside and outside of the health care system. Perhaps this is due to the higher stakes students place on being culturally safe and the professional responsibility of their nursing role. The gravity of which can add to a sense of moral distress. This is further exacerbated by the existence of power differentials, lack of voice, hospital policies, and systemic racism. Similar distress is documented in research in which nurses are confronted with the unaddressed social determinants of health influences such as poverty, housing, and powerlessness (Wros, et al., 2021), as well as confronting the predominant contemporary Canadian narrative of multiculturalism, inclusivity, and tolerance promoted in our daily interactions in society and which we implicitly support within our nursing profession to the exclusion of addressing individual and systemic racism. (Hilario, et al., 2018; Varcoe, et al., 2019). These testimonies underscore the continued potential for healthcare services to be unsafe and traumatic spaces for Indigenous people.

Indigenous Health as Required Curriculum

In their report on *Bringing Reconciliation to Healthcare in Canada: Wise Practices for Healthcare Leaders*, Richardson and Murphy (2018) conclude that there is still much work to be done in recognizing Indigenous peoples' rights to self-determination in health and wellness programming. They identify three interrelated priority objectives for healthcare leaders seeking to advance reconciliation, including to "re-align authorities, accountabilities, and resources;

eliminate racism and increase cultural safety; and ensure equitable access to healthcare" (Richardson & Murphy, 2018, p. 1)**.** This directive speaks to the pressing work that must be undertaken to develop curricular content in nursing that will result in the understanding and uptake of cultural safety work. It requires a shift from a pathological and racialized construct of Indigenous health and culture to one in which healthcare providers look inward and critically examine their personal role in supporting oppressive societal structures. It is critical that providers understand how their own positionality, bias, power, privilege, and worldview shape how they walk in the world and impact those around them (Gaudry, 2016; Green, 2016; Ward, Fridkin, & Fridkin, 2016; Ward, Ninomiya, & Firestone, 2021). Students who had completed the Indigenous wellness course were given the opportunity to engage with critical race theory, colonization, and Indigenous community knowledge and reflect on the value of integrating these concepts into practice. Although the survey demonstrated majority support for this work, there remained some uncertainty in student confidence to disrupt racialized interactions, and to feel fully prepared for interactions with Indigenous clients. This could imply the need to support their professional growth in this regard, or to interrogate their reliance on relational practice. As nurse educators continue to develop content to address racial inequities, we must find ways to increase comprehension and uptake of critical knowledge that results in improved clinical environments for Indigenous patients/clients (Bell & Dalen-Smith, 2021; Garland & Batty, 2021; Kennedy, et al., 2021).

Limitations of the project

The qualitative component of this research had a sample size of 16 participants whom provided rich narrative descriptions of their experience and had consistent overlap in themes and insights. This supports the researcher view that this sample met accepted standards for

qualitative sample size adequacy as discussed by Vasilieu et al (2018). The ability to make inferences with the quantitative survey results was limited however, by its small sample size. We also did not know the participants baseline knowledge related to the survey questions to be able to determine a change in scores pre-post course. The low numbers of respondents to the quantitative survey may also indicate respondent bias of those students who are actively interested in this content knowledge. Researchers also acknowledge that Q6 should have been separated into two questions addressing personal and professional roles separately. There was also no participant demographic information collected in order to maintain anonymity but this aspect of information may have added to the discussion and implications of the data.

There was also some limitations embedded within our overall choice of survey as our data collection method. Gaining qualitative narrative data through survey limits follow up discussions with participant, the ability to probe more deeply and engage in relational learning that may be experienced if we were using an alternate method. Anonymous data collection also limits the ability to incorporate participant positionality and reflection on personal worldview influences. Future methodology considerations may include shifting to an Indigenous methodology such as visiting, storytelling, or circle work.

Conclusion

The purpose of this mixed method study was to provide an opportunity within a safe and anonymous space for nursing students to explore their own confidence and potential feelings of uncertainty while applying decolonizing knowledge to their nursing clinical practice regarding interactions with Indigenous clients. Students were asked to explore and describe their own experience, both successes and challenges, of integrating knowledge into practice.

Survey respondents spoke about their observations with colleagues in complex racialized scenarios, as well as about system challenges, relationships with Indigenous peoples, and the strengths present within Indigenous healing and community supports.

Overall, students acknowledged that Indigenous content in the core nursing curriculum was beneficial and improved their knowledge and confidence regarding Indigenous history, health, culture, community, and traditional practices. Students commented on the presence of Indigenous wellness practices and supports in acute care settings and their own understanding of the value of these practices to the patient. They also identified the limitations they experienced through system issues such as client mistrust, resource scarcity, and power differentials. Some students also commented, that despite the knowledge they had acquired through the course, they continued to experience uncertainty with regards to engaging with difficult and complex situations like trauma history or disrupting racial tension on the unit.

As educators, our reflection on the participant responses indicates that there is an optimistic enthusiasm for decolonizing knowledge of Indigenous contexts. Respondents want to build anti-racism and equity into their practice. We also see that some uncertainty exists when applying this knowledge to practice which speaks to the onus on educators to support students to develop skills in application. Despite many students' narratives containing dismaying examples of stereotyping, racism, disrespect, and discrimination, the Likert scale responses indicated students' positive self assessment with the learning outcomes and students' positive descriptions of their experiences as allies and advocates for Indigenous peoples which indicates the possibility of a more culturally safe and inclusive future.

Future research would benefit from expanded input from students to capture diverse experiences and reflections. This might include further development of the quantitative survey

that could capture the knowledge to practice concepts under study. Including demographic information on respondents would also assist in gaining insight into the complex reflections on the experiences Black and People of Color (BPOC) and the relationship with Indigenous communities. In addition, refinement of survey questions with pre-testing may strengthen the content validity of the data.

Other research might include:

- Further explore the reasons for uncertainty and potential supports as perceived by students.
- Explore the placement of content such as trauma-informed care, critical race theory, and Indigenous knowledge within the sequence of nursing curriculum.
- Explore in greater depth student comprehension of culturally responsive approaches to care vs. uptake of antiracist and critical race theories.
- Study specific agency/unit cultures, contexts and the supports and barriers to maintaining an antiracist nursing practice tailored to specific environments.

Appendix A

Concept Definition

- **Anti-racist**

  An approach that considers systemic influences and requires disruption of the status quo of settler privilege. (St Denis, 2017)

- **Culture**

  "The accumulated socially acquired result of shared geography, time, ideas and human experience" (Ramsden, 2002, p. 111).

- **Cultural Safety**

  A term and framework developed by Irihapeti Ramsden to invoke thought around power differentials in relation to patient care and outcomes allowing each patient to determine what is safe for them. Defined as "Cultural Safety is simply a mechanism which allows the consumer to say whether or not our service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give the power to the consumer. Designed as an educational process by Maori, it is given as a koha to all people who are different from the service providers whether by gender, sexual orientation, economic and educational status, age, or ethnicity. It is about the analysis of power and not the customs and habits of anybody. In the future it must be the patient who makes the final statement about the quality of care which they receive." (Ramsden, 2002, p. 181).

- **Cultural Sensitivity**

  "Alerts students to the legitimacy of difference and begins a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others" (Ramsden, 2002, p. 117). Often used interchangeably with *Cultural Safety* but actually holds the place prior to achieving *Cultural Safety*.

- **Culturally responsive**

  An approach that considers cultural differences as reasons for problematic issues to arise (St. Denis, 2017).

- **Personal tension**

  Intrinsic unease felt by nursing students around their personal beliefs, values, and uncertainties in relation to providing care for Indigenous patients.

- **Uncertainty**

  In this project uncertainty refers specifically to the feelings experienced by nursing students when reflecting on their own self-interrogation and interactions with Indigeneity, racism, and nursing practice. Our use of the term builds on Dion's (2007) work in which she invites her students to create a file of (un)certainties (p. 334) which positions self-interrogation juxtaposed with Indigenous tropes and learnings at the center of exploration. Within our nursing context we utilize uncertainty to invite students to explore complex situations in which the course of action may not always be apparent or easily navigated.

- **Cultural tension**

  We have utilized 'cultural tension' to indicate the uncertainty or unease that may be experienced by nursing students related specifically to the interactions between nurse-client of diverse racialized/ethnic backgrounds. Cultural tension need not only imply a negative interaction but one of uncertainty regarding ways for nurses to interact and support clients that do not 'offend' or 'trigger' a negative experience for the client. Cultural tension has been defined in the literature as an individual experiencing tension

between their own culture and that of the dominant culture of the society or organization in which they live/work (Chung Yan, 2008).

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