A CRITICAL DISCOURSE ANALYSIS OF NURSING'S RESPONSE TO ANTI-INDIGENOUS RACISM IN HEALTHCARE

by

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Abstract

Background: The impact of colonization, assimilative policies, genocide and the disruption of Indigenous Knowledge systems through the imposition of Western bio-medical supremacy within Canada's healthcare system has fractured and harmed health and healing practices that have otherwise contributed to healthy Indigenous communities and populations since time immemorial. The harm stemming from colonization and anti-Indigenous racism within healthcare and nursing have resulted in gross inequities and poor health outcomes for Indigenous Peoples in Canada. Nurses play a key role in addressing discourses about anti-Indigenous racism in health systems and the health inequities impacting Indigenous Peoples. The **objectives** of this thesis are to draw on key policy texts as an entry point for exploring and describing the various discourses, contextual factors, and socio-political trends that influence nursing's engagement with policies related to Indigenous Peoples' health. **Methods:** Primary data was collected from numerous text-based sources via provincial, national and international nursing organizations, including reports, policy products, descriptive articles and print-based intervention materials. This study was guided by critical discourse theory, critical race theory and critical Indigenous theory to analyze the factors, contexts and political trends that influence nursing's engagement with Indigenous health policies in the Canadian context. Methodologically, critical discourse theory informed the basis of my inquiry in understanding the nature of an intended audience as a variable, where nursing discourse is examined to characterize the audience of nursing regarding its relationships as a profession with Indigenous health policies. **Conclusions:** These findings have implications for the promotion of Indigenous health and well-being through the disruption of anti-Indigenous racism in health systems by investigating nursing's role and relationship with Indigenous health policies. In response to intervention materials directed at anti-Indigenous

racism in healthcare, this study supports the nursing profession in actioning their positionality to disrupt harmful colonial systems and provide culturally safe healthcare and access for Indigenous Peoples.

Lay Summary

The impact of colonization and anti-Indigenous racism in healthcare has led to poor health outcomes for Indigenous Peoples in Canada. Nurses play an important role within the healthcare system to stop all forms of anti-Indigenous racism and address ongoing harm that impacts Indigenous Peoples. To better understand the role of nurses in addressing anti-Indigenous racism within healthcare systems, this study examines nursing policy texts to explore how nurses do or do not discuss Indigenous-led policies and government mandates related to Indigenous Peoples' health within the nursing profession. To address these issues, this study outlines key considerations for nursing to promote Indigenous health and well-being by implementing and advancing Indigenous-led policies and promoting cultural safety within healthcare and nursing practice.

Preface

This thesis is the original, unpublished and independent work of Dawn Tisdale, student in the Master of Science in Nursing degree program at the University of British Columbia. The writing of this thesis was completed with the guidance, collaboration, input and mentorship of Dr. Annette Browne as primary supervisor and committee members Dr. Sally Thorne and Elder Gwen Campbell McArthur. Elder Gwen Campbell McArthur provided Elder teachings and Indigenous Knowledge in support of myself and this research.

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List of Abbreviations

ARNBC Association of Registered Nurses of British Columbia

BC British Columbia

BCCNM British Columbia College of Nurses and Midwives

BCNU British Columbia Nurses' Union

CASN Canadian Association of School of Nursing

CDA Critical Discourse Analysis

CFNU Canadian Federation of Nursing Unions

CINA Canadian Indigenous Nurses Association

CNA Canadian Nurses Association

CNSA Canadian Nursing Students' Association

CRNBC College of Registered Nurses of British Columbia

DRIPA Declaration on the Rights of Indigenous People Act

FNHA First Nations Health Authority

IBPOC Indigenous, Black, People of Colour

ICN International Council of Nurses

ICS Indigenous Cultural Safety

MNBC Métis Nation of BC

NGO Non-Governmental Organization

NNPBC Nurses and Nurse Practitioners of British Columbia

NWAC Native Women's Association of Canada

RCAP Royal Commission of Aboriginal Peoples

TRC Truth and Reconciliation Commission

UBC University of British Columbia

UN United Nations

UNDRIP United Nations Declaration on the Rights of Indigenous People

Acknowledgements

Thank you to Elder Evelyn Voyageur, Elder Gerry Oleman and Elder Gwen Campbell McArthur for your love, care and guidance over the years. Your teachings have healed me and always guide me.

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Dedication

This thesis is dedicated to my grandmother Florence Roy and my son Aaron Tisdale.

Chapter 1: Introduction

1.1 Land Acknowledgement and Situating Self in the Research

Many Indigenous Nations across Turtle Island hold protocols that demonstrate the essential nature of acknowledging who you are, where you come from, and the respectful recognition of the land and people you are entering into relationship with. Elders and Knowledge Keepers have taught me that introductory protocols are necessary to foster a foundation of trust and respect when cultivating new relationships. In the same way one would not enter someone's house without knocking or introducing oneself, one would not occupy someone's homeland nor greet someone new without beginning with acknowledging the other person or Peoples first.

In addition to the cultural value of land acknowledgments, there is also a contemporary political component that offers insight and recognition of people's relationship with the land they live on, including one's identity and history with the land. For people conducting a land acknowledgement on territories that have been colonized, this practice can provide critical self-reflection into the socio-political impact of colonization and the relationship between Indigenous Peoples and Settler society including the exploration of concepts of sovereignty, racial identity, settler identity, colonization, colonialism, land dispossession, Indigeneity, Whiteness, forced displacement and land reclamation. Land acknowledgments are not only an opportunity for introspection but, for Canadians, they also offer an examination of the historical and current socio-political relationships of the more than 50 Indigenous sovereign nations of northern Turtle Island and Canada. In this way, I would like to acknowledge with deep gratitude and respect that I have conducted this research on the unceded and occupied territory of the Coast Salish peoples, including the territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Sto:lō and səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations who have stewarded these lands and all living

beings of this land since time immemorial. Many of the teachings and Indigenous Knowledge that has informed this thesis and my work to build Indigenous Cultural Safety within healthcare systems were shared with me through the mentorship and care of respected Elders and Knowledge Keepers from these lands who have graciously guided me and many others despite the ongoing violence and harm of land dispossession, assimilation and genocide resulting from colonization.

By way of introduction, my relationship to these lands of the Coast Salish Peoples is as an uninvited guest of mixed ancestry. My father was a White settler of Ukrainian ancestry, and my mother is of mixed ancestry of Irish, French and Mi'kmaq. My grandmother, Florence Roy, was born in 1911 on the Bad River Reservation of the Lake Superior Tribe of Chippewa Indians in what is colonially known as Northern Wisconsin and, based on my family's knowledge and research, my grandmother was of mixed Acadian and Mi'kmaq ancestry from the lands of the Wabanski Confederacy with further ancestry from Northern Anishinaabeg territory.

Due to pervasive anti-Indigenous racism, assimilative processes and gender-based discrimination within Canadian legislation of the *Indian Act*, my grandmother and familial connection to our Indigeneity was greatly disrupted. Most of my maternal family and I grew up on the lands of the Haudenosaunee within White Catholic Irish and French culture with White settler privilege. For most of my adulthood I have been on a complex reflexive journey to better understand myself, the relationship between my Indigeneity and my White settler identity for my family and, in more recent years, my nursing identity working in Indigenous Health Policy, and Indigenous Cultural Safety Education.

Sharing the personal details of this journey is beyond the scope of this thesis; however, it is critical that I share how my identity informs my professional practice and by extension my

motivation for this research study. It is necessary that I acknowledge that I grew up White passing, with White privilege, which has afforded me many advantages in all aspects of my life including educational spaces, nursing school, and my professional practice and leadership roles. My White settler identity has given me numerous tools that have equipped me well to navigate colonial systems. In regard to my Indigenous ancestry, I am in an ongoing and ever-evolving reflexive journey to uncover and reclaim knowledge about my family history under the guidance of Elders and mentors.

As an act of reclamation and deep love and appreciation for my grandmother Florence Roy and my ancestors who resisted colonial genocide, I understand my existence as an act of ongoing resistance in celebration of my Indigeneity. I intentionally recognize my Indigeneity for my ancestors, myself and for future generations, including my son. In an era of violent acts of appropriation related to falsified Indigenous identity, I acknowledge that Indigenous identity and for those of us who are of mixed Indigenous and Settler identity within Canada is complex, contested, and challenging. As I learn more about my family and the complexity of my connections to being Mi'kmaq, I am wanting to do so in a way that is culturally safe while also honouring my grandmother and family lineage. In this way, I have committed myself personally and professionally to addressing ongoing colonial harm, anti-Indigenous racism and health inequities in connection to my mixed ancestry and how I am socially located in these contexts. It is my ongoing responsibility to engage in reflexive practice of how I take up space in the collective mission to address anti-Indigenous racism in nursing and healthcare.

1.2 Discourse and Nursing's Response to Addressing Anti-Indigenous Racism

I set the foundation of analysis for this thesis by examining what guides nursing's responses and actions in disrupting widespread inequities and systemic anti-Indigenous racism

within healthcare. Using Critical Discourse Analysis and the theoretical lenses outlined in chapter two, I provide a synthesis of literature below that serves as background and context for the analysis informed by the data in Table 1: *Corpus of Discourse Samples (text).* A primary focus of this thesis uses the following data corpus as an entry point for exploring the various discourses, contextual factors, and contemporary socio-political trends that influence the ways nursing responds or engages with calls to action outlined in Indigenous-led policies, legislation and reports. Table 1: *Corpus of Discourse Samples (text)* is positioned below, at the beginning of this thesis, to orientate the analysis and findings in a way that examines the data in the form of policy and nursing organizational documents to contextualize discourse pertaining to nursing's response to addressing anti-Indigenous racism in health care and within the nursing profession. I continue to refer to the various texts, position statements, and policy documents outlined in Table 1 in the Chapters that follow as I form the arguments and ultimately, recommendations that are featured in this thesis.

1.3 Table 1: Corpus of Discourse Samples (text): Indigenous-led Policies and Nursing Organizational Documents

Genre	Source/ Author	Title	Year	Characteristics of the Text	Underpinning Concepts and Recommended Actions
Government/ Policy Mandates	Provincial	*Declaration on the Rights of Indigenous Peoples Act of British Columbia*	2019	The BC provincial government passed the Declaration on the Rights of Indigenous Peoples Act (Declaration Act) into law in November 2019. DRIPA established the United Nations Declaration on the Rights of Indigenous Peoples (UN Declaration) as the Province's framework for reconciliation, as called for by the Truth and Reconciliation Commission's Calls to Action.	The Declaration Act provides a framework to uphold the human rights of Indigenous Peoples through improved transparency and predictability between the BC government and Indigenous Peoples, including nation to nation relationships. DRIPA mandates government alignment with UNDRIP, and requires BC to develop an action plan and provide annual reports on its implementation progress. The dissonance between DRIPA's full adoption within the province of BC and ongoing settler colonialism, as evident through existing Indigenous human rights violations, creates numerous barriers to DRIPA's implementation.
	National	*Section 35 of the Constitution Act*	1982	Section 35 of the Constitution Act was the formal recognition of Aboriginal rights by	In 1982 Indigenous leaders advocated for the inclusion of Aboriginal rights to be recognized in the Canadian Constitution in hopes that this would support the protection

				the Canadian government through the enshrined Section 35 of the Canadian Constitution.	of Aboriginal rights. While this formal recognition did occur in Section 35 in 1982 and is highly significant, it does not define these rights and requires that the rights be defined via the legal system on an independent basis. In addition, Section 35 defines Aboriginal Rights through the Crown and Canada but Aboriginal sovereignty and, by extension, Aboriginal rights exist beyond colonial-settler governments and states.
	International	*United Nations Declaration on the Rights of Indigenous Peoples*	2007	UNDRIP is an internationally recognized instrument adopted in 2007 by the United Nations to enshrine, protect, and affirm the distinct rights of Indigenous Peoples globally.	Canada initially refused to adopt UNDRIP and only in 2010 did the Canadian government reverse their decision and begin to take steps towards its endorsement. In 2021, 14 years after UNDRIP's inception, Canada established the United Nations Declaration on the Rights of Indigenous Peoples Act, which provides a roadmap for UNDRIP's implementation. While this official endorsement is a positive step forward, there remain many challenges and barriers for Canada to action UNDRIP in a meaningful way.
Nursing Organizations	British Columbia College of Nurses & Midwives	*Declaration of Commitment of Cultural Safety and Cultural Humility*	2017	The College of Registered Nurses of British Columbia (CRNBC), predecessor of BCCNM, pledges	The *Declaration of Commitment of Cultural Safety and Cultural Humility:* • Outlines the importance of and need for healthcare system leaders to embed

			their commitment to integrate cultural safety and cultural humility into its practice as a health regulator and BCCNM continues this ongoing commitment.	cultural safety and humility into all areas of healthcare practice. • Is aspirational in nature. • Does not outline clear and measurable processes for implementation nor accountability measures. • BCCNM pledged their commitment on their website after its release.
	Racism in Healthcare: An Apology to Indigenous Peoples and a Pledge to be Anti-Racist	2021	In a follow-up to the *In Plain Sight* report, BCCNM formally apologizes for the harm suffered due to anti-Indigenous racism within healthcare and nursing, and pledges to adopt anti-racism practices within nursing regulation and establish clear accountability measures for cultural safety and humility in nursing regulation.	The *In Plain Sight* report is referenced as the conduit for this apology (no other Indigenous-led policies are discussed). The apology outlines clear measures of accountability to address anti-Indigenous racism in healthcare and outlines the role of nursing regulators in this work as per the recommendations from the *In Plain Sight* report. On the one-year anniversary of the apology, BCCNM published a progress report.
	BCCNM's Commitment: Constructive disruption to	2021	BCCNM's Commitment document outlines the regulatory body's uptake and	The commitment document outlines the need for accountability to address anti-Indigenous racism, a description of the

	Indigenous-specific racism amongst B.C. Nurses and Midwives		enactment of the recommendations put forth in the *In Plain Sight* report.	current state and why there is a need to focus on anti-Indigenous specific racism, the methodology used, and an action plan describing the role of nursing regulators as per the recommendations from the *In Plain Sight* report. In its literature review, additional policies documents are referenced: *TRC, UNDRIP, DRIPA, Reclaiming Power and Place: The Final Report for the National Inquiry into MMIWG*
	Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard	2022	The BCCNM professional practice standards and companion guide clearly set out the expectation for registrants' responsibilities to adopt cultural safety and humility within nursing practice, the expectation for ongoing education, and the duty to report incidents of anti-Indigenous racism.	The Indigenous Cultural Safety, Cultural Humility and Anti-Racism practice standard and accompanying guide were created to outline registrants' responsibilities to practice in a culturally safe way through Self-reflective practice: • Building knowledge through education • Anti-Racist practice • Creating safe health-care experiences • Person-led care • Strengths-based and trauma-informed care
Nurses and Nurse	*ARNBC Statement of*	2016	The Association of Registered Nurses of	*ARNBC Statement of Commitment on Aboriginal Health* identifies actions to

	Practitioners of British Columbia	*Commitment on Aboriginal Health* (see Appendix A)		British Columbia (ARNBC), predecessor of NNPBC, states its commitment to engage nurses and the provincial nursing association in disrupting inequities faced by Indigenous Peoples.	represent its commitment to addressing health inequities impacting Indigenous Peoples as: • Create a designated Board of Director position to represent matters affecting Indigenous health and Indigenous nurses in BC. • Develop a position statement on Aboriginal Leadership Capacity and Engagement • Establish a program that provides a pathway for Indigenous nursing leadership development. • Prepare resolutions with respect to issues associated with Aboriginal health to the CNA Annual General Meeting. • Develop an Indigenous nurses Community of Practice in BC.
		NNPBC Commitment to Indigenous Health	2020	NNPBC states its commitment to Indigenous Health within the province of BC	*NNPBC's Commitment to Indigenous Health* recognizes nursing's role and responsibility to commit to action and adopt Indigenous cultural safety and humility within NNPBC and the nursing profession. Actions taken to date include the following: • Appointment of the Indigenous Board Director to inform representation on matters affecting Indigenous health, Indigenous nurses and nurse practitioners, and the health of Indigenous Peoples in British Columbia.

				• Building capacity for Indigenous leadership and engagement through advocacy. • Commitment to developing and maintaining a voluntary self-disclosure of Indigenous ancestry on the membership application. • Initiation and support for a team focused on Indigenous health to advise NNPBC on matters related to Indigenous health nursing practice and policy. • Preparing resolutions on issues associated with Indigenous health. • Continuing to address institutional racism and barriers encountered by Indigenous Peoples.
	Upholding the Truth and Reconciliation Recommendations	2021	NNPBC identifies Indigenous health as a key priority in the form of an Issues Brief	Key issues identified are the implementation of the TRC, the identification of anti-Indigenous racism found in the *In Plain Sight* report, and inequities related to access to care during the COVID-19 pandemic. NNPBC calls for action within healthcare systems to address anti-Indigenous racism. There are no clear guidelines for accountability or process for NNPBC to action past and future work.
	Understanding Allyship	n.d.	NNPBC identifies the need to disrupt anti-Indigenous racism as outlined in the calls to action of the TRC and	Recommendations are to work towards allyship based on actions outlined in the Anti-Oppression Network, TRC Calls to Action, and *In Plain Sight* report. The recommendations are to:

				the *In Plain Sight* report recommendations. This document discusses the role of the professional association in allyship.	• Acknowledge one's privilege and colonial power within inequitable systems • Recognize the history of the traditional unceded Indigenous lands one resides on and support Indigenous sovereignty • Seek opportunities to learn from Indigenous Peoples and communities • Respect Indigenous Peoples' connection to the land and the impact of colonial activities • Support ongoing education around allyship • Be open to feelings of discomfort when learning about Indigenous Peoples and terminology • Do not expect recognition or reward for supporting Indigenous human rights
BC Nurses' Union	*Indigenous Leadership Circle*	2005	Established in 2005, BCNU's Indigenous Leadership Circle (ILC) aims to support opportunities for Indigenous nurses to have a voice in nursing organizations and governance structures.	The ILC engages in ongoing participation in provincial and national organizations that contribute to advancing Indigenous health status outcomes.	

	Position Statement: Indigenous Health	2013	Following the recommendations outlined in the Native and Inuit Nurses Association of BC and FNHA's report *Future Directions for Indigenous Nursing in British Columbia,* BCNU recognizes the need for nurses to adopt Indigenous cultural competency and safety to address cultural differences that can contribute to challenges in access to care and other inequities.	BCNU's *Position Statement on Indigenous Health* aims to: • Ensure ICS and cultural competency in practice • Recognize the role nursing has in improving the health status of Indigenous Peoples in BC • Improve access to care for BC First Nation communities • Educate nurses on the impacts of colonialism, the social determinants of health, and policies/legislation that affect the health of Indigenous Peoples • Endorse PHSA's San'yas ICS training for nurses
	Bulletin: International Nurses Day: An apology to Indigenous Peoples	2022	BCNU releases a bulletin in 2022 that reaffirms its commitment to a genuine and just process of reconciliation with Indigenous Peoples and	The bulletin *International Nurses Day: An apology to Indigenous Peoples* recognizes International Nurses Day and the legacy of colonialism within nursing and the healthcare system that specifically targeted Indigenous Peoples. Following the *In Plain Sight* report, and with the support of the ILC, BCNU offers a sincere apology to Indigenous Peoples for the racism and harm they have

			Indigenous union members.	experienced at the hands of nurses and the nursing profession.
	Bulletin: Support for the inquiry and final report of MMIWG2S	2019	BCNU calls for support during the inquiry into Canada's Missing and Murdered Indigenous women in a formal letter to the Prime Minister and endorses the final report and findings when it is released in 2019.	BCNU states that they stand with those impacted by the findings of the final report for MMIWG and invites all Canadians to review the "Calls to Justice." BCNU does not outline nurses' role in this work.
Canadian Indigenous Nurses Association	*Nothing available on website for non-members*			
Canadian Nurses Association	*Code of Ethics for Registered Nurses*	2017	The 2017 Nursing Code of Ethics for Registered Nurses recognizes the need to support Indigenous rights in the context of healthcare.	The *Code of Ethics for Registered* Nurses (2017) states that "Nurses respect the special history and interests of Indigenous Peoples as articulated in the Truth and Reconciliation Commission of Canada's (TRC) Calls to Action (2015) … Calling on all levels of government to acknowledge the current state of Indigenous health in Canada and to implement healthcare rights and take actions

				with Indigenous Peoples to improve their health services (TRC, 2015)"
	Nursing Declaration against Anti-Indigenous Racism in Healthcare	2021	In support and recognition of UNDRIP and the TRC, CNA recognizes and unconditionally condemns all acts of racism and discrimination against Indigenous Peoples and calls for social justice to address racism and health inequities in Indigenous communities.	The Declaration states that CNA: • Recognizes anti-Indigenous racism is a national health crisis • Commits to disrupting harm and combatting bias, prejudice, and racism within ourselves, nursing organizations, and communities • Will develop strategies, goals, and accountability measures to address health inequities • Supports the TRC's Call to Action #19, 20, 22 and 24 • Urges nurses to build ICS and cultural competence in nursing practice • Will advocate for healthcare policy at all levels of government to address health and social inequities impacting Indigenous Peoples The Declaration is an important policy measure for Canadian nursing though it is aspirational in nature and does not clearly outline accountability measures or progress reporting.

	Promoting Cultural Competence in Nursing	2010 and 2018	CNA positions that cultural competence is a professional and ethical responsibility of nursing and should be an entry to practice level requirement and ongoing professional development for all nurses.	This position statement asserts CNA's commitment to cultural competency and cultural safety to provide high quality, safe, and equitable nursing care. This document frames cultural competency as supporting respect for all cultures and persons accessing care. The term cultural safety is recognized as stemming from Indigenous health contexts to address social injustice and unequal power relations; however, the term is used as applicable to all people receiving care.
	Aboriginal Health Nursing and Aboriginal Health: Charting Policy Direction for Nursing in Canada	2014	The *Aboriginal Health Nursing and Aboriginal Health: Charting Policy Direction for Nursing in Canada* was developed in support of a resolution adopted by CNA in 2012 regarding an Aboriginal Nursing Strategic Plan and co-developed by CNA and ANAC (now CINA) to provide a guide for policy development to strengthen and improve Aboriginal health	The five priorities for strategic action were: • Integration of Indigenous Ways of Knowing and being • Addressing institutional barriers to Aboriginal health nursing and Aboriginal health • Education • Recruitment and retention • Building capacity for Indigenous nursing leadership and advocacy

			nursing, leadership, and Aboriginal health.	
Canadian Nursing Students' Association	*Position Statement: Establishing a Voting Director Position for Indigenous Health Advocacy*	2017	An Indigenous voting position is established within CNSA bylaws.	The aims of establishing an Indigenous Health Director on the CNSA board of directors is to support the TRC and to action the 2015 position statement to promote cultural safety within CNSA.
	Position Statement: Cultural Safety in the Context of Aboriginal Health in Nursing	2015	CNSA advocates for the inclusion of Indigenous Ways of Knowing in Canadian nursing curricula to enhance the cultural competence of new graduate nurses and build cultural safety within CNSA and nursing practice.	The aim of this position statement is to adopt cultural safety into nursing curricula and within all areas of nursing practice to address health inequities affecting Indigenous Peoples.
	Resolution Statement Creating a Partnership for Aboriginal Health Promotion	2015	CNSA adopts a resolution to create partnerships with key stakeholders and support Aboriginal nursing leadership.	CNSA commits to: • Create a new partnership with ANAC (now CINA) • Develop an Aboriginal nursing representative position • Advocate for the inclusion of Indigenous Ways of Knowing and education

				regarding Indigenous Peoples' health throughout Canadian schools of nursing
Canadian Association of Schools of Nursing	*CASN Statement of Commitment Anti-Indigenous Racism*	2021	CASN makes a statement to address anti-Indigenous racism within nursing and healthcare and unanimously adopts a motion to respond to the TRC Calls to Action.	CASN commits to advance leading practices, equity, and the national response to the TRC Calls to Action in nursing education and scholarship. CASN will: • Develop an annual survey to address the implementation of recruitment and retention strategies outlined in the *Framework of Strategies for Nursing Education to Respond to the Calls to Action of Canada's Truth and Reconciliation Commission* • Release a series of education modules and lunch and learns for educators to support the efforts of the Framework
	Framework of Strategies for Nursing Education to Respond to the Calls to Action of Canada's Truth and Reconciliation Commission	2020	The aims of the F*ramework of Strategies for Nursing Education to Respond to the Calls to Action of Canada's Truth and Reconciliation Commission* is to provide direction to schools of nursing to respond to the TRC and	The Framework provides foundational strategies to: • Build partnerships • Support faculty by developing ongoing education and professional development • Address recruitment and retention of Indigenous nursing students and faculty • Implement ICS and anti-racism education within nursing curricula

			provide national strategies to support decolonization and Indigenization.	
Canadian Council of Registered Nurse Regulators	No Data Available			
Canadian Federation of Nurses Unions	*News Release: Nurses call for justice on National Indigenous Peoples Day*	2020	Marking National Indigenous Peoples Day on June 21st, CFNU calls for justice regarding Indigenous Peoples and the legacy of harm related to Canada's history of colonization and its ongoing practices.	The news release recognizes the need for collaborative efforts to action reconciliation and decolonization to address widespread anti-Indigenous racism and how nurses play a strong role in these advocacy efforts. The final report for the National Inquiry into MMIWG is highlighted as a current and ongoing example of violence and harm where one year after the final report's release, the federal government has failed to act. While the news release does implicate nursing in addressing anti-Indigenous racism, it does not discuss how and in what ways nursing will do this.
	News Release: Canada's nurses welcome the final report of the	2019	CFNU welcomes and recognizes the final report of the National Inquiry into MMIWG	This news release calls on government and Canadians to address the violence and harm concluded in the final report and acknowledges that nurses must do their part

		national Inquiry into MMIWG			to address ongoing harm but does not state how.
	International Council of Nurses	*Position Statement*: *Cultural and Linguistic Competence*	2013	ICN Position statement *Cultural and Linguistic Competence* aims to demonstrate the importance of cultural competence within nursing practice.	ICN outlines that nurses should demonstrate cultural competence to all patients by: • Developing cultural awareness of self and of those from different backgrounds and cultures • Accepting and respecting cultural differences, providing culturally appropriate care to all patients for the best possible care outcomes There is no specific language or acknowledgement of Indigenous Peoples.
Indigenous-led Policies and Reports	Provincial	*In Plain Sight Report Addressing Indigenous-specific Racism and Discrimination in B.C. Healthcare*	2020	The *In plain Sight* report was commissioned through British Columbia's Minister of Health to conduct a review of Indigenous-specific racism in BC's healthcare system.	The findings section describes a major problem of Indigenous-specific racism in the B.C. healthcare system. The systemic anti-Indigenous racism described has significant impacts on Indigenous patients accessing care.
	National	*Royal Commission on Aboriginal Peoples*	1996	The *Royal Commission on Aboriginal Peoples* began in 1991 by Order in Council in response to ongoing Indigenous	The primary mandate of the commission was to investigate and propose recommendations to address issues related to Indigenous Peoples' rights and to support the relationship between Indigenous Peoples and the

			rights violations within Canada. The final report was released in 1996.	Canadian government in the spirit of nation to nation relations. The final report made clear recommendations related to health and healing in Chapter 3, sections 3.31-3.325. While many of the recommendations were not actioned, the final report was instrumental in garnering political support for the TRC.
	Truth and Reconciliation 94 Calls to Action	2015	The Indian Residential Schools Settlement Agreement began its process in 2007. An outcome of the agreement was the establishment of the TRC to facilitate reconciliation among former students, their families, and their communities and to build awareness for all Canadians. In 2015, the TRC presented the executive summary of the findings contained in its multi-volume final report, including 94 Calls to Action to	The TRC Calls to Action numbers 18-24 are focused on health with #24 specifically addressing nursing: "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."

			further reconciliation between Canadians and Indigenous Peoples. As part of the Indian Residential Schools Settlement Agreement, Prime Minister Justin Trudeau accepted the Final Report of the Truth and Reconciliation Commission on behalf of Canada.	
	Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls	2019	*Reclaiming Power and Place* reveals the targeted human and Indigenous rights violations and violence impacting Indigenous women, girls, and 2SLGBTQQIA people within Canada.	The Calls for Justice of the Final report *Reclaiming Power and Place* target health and wellness in calls to action numbers 3 .1 - 3.7. #3.2 calls on government to provide "adequate, stable, equitable, and ongoing funding for Indigenous-centered and community-based health and wellness services that are accessible and culturally appropriate, and meet the health and wellness needs of Indigenous women, girls, and 2SLGBTQQIA people. The lack of health and wellness services within Indigenous communities continues to force Indigenous

				women, girls, and 2SLGBTQQIA people to relocate in order to access care."
	Joyce's Principal	2020	Joyce's Principle is in memorial of Joyce Echaquan, who died in 2020, and is a formal request for governments in Canada and their institutions to respect and protect Indigenous rights relative to healthcare and social services that are recognized internationally through UNDRIP.	The expectation was for Joyce's Principle to be adopted by the National Assembly of Quebec and by the House of Commons from Canada without delay. Joyce's' Principle has yet to be formally adopted by governments as of 2023. "Joyce's Principle aims to guarantee to all Indigenous Peoples the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health. Joyce's Principle requires the recognition and respect of Indigenous Peoples' traditional and living knowledge in all aspects of health."
	Out of Sight: Interim report of the Sinclair Working Group	2017	The *Out of Sight: Interim report of the Sinclair Working Group* provides recommendations aimed at addressing anti-Indigenous racism within healthcare systems in honour and memory of Brian	The recommendations of the *Out of Sight* report are: • For all levels of government and the healthcare system to adopt explicit anti-racism policy with accountabilities outlined for planning, implementation, and progress and that these measures be led by Indigenous Peoples • That all health professional schools adopt anti-racism curriculum and that care providers take anti-racism and cultural

	Sinclair's death in 2008.	safety training, including ongoing professional development • That all healthcare organizations adopt clear positions of zero tolerance for racism in the workplace and develop complaints processes aimed to eliminate anti-Indigenous racism within the healthcare system.

1.3 Research Focus and Research Questions

This research explores the ways in which nursing locates itself in contributing to systemic anti-Indigenous racism[1] and how it understands its positionality to engage with and actively work towards its disruption. Examining systemic anti-Indigenous racism brings into focus the need for structural changes to disrupt the embedded institutionalized systemic racism that is inherently built in to all levels of Canada's health systems. Systemic racism moves away from conceptualizing racism as isolated interpersonal acts of racism, but rather, the often insidious way racism upholds inequitable, discriminatory and harmful socio-political norms through policies, practice and belief systems that maintain the status quo of systems within Canada (Beagan et al., 2023). To support this analysis, the central research questions of this study are these:

a) How does nursing as an organized discipline respond to anti-Indigenous racism in healthcare, specifically systemic racism as it manifests in relation to anti-Indigenous racism?
b) In what ways does nursing, at a health systems or structural level, respond to or engage with calls to action outlined in Indigenous led policies, legislation, and reports?
c) What guides nursing's responses and actions in disrupting widespread inequities and systemic anti-Indigenous racism? What are the implications of these responses?

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[1] In this thesis the focus will be on anti-Indigenous racism. The aim of this focus is not to minimize or engage in comparisons regarding the depth of violence or harm when examining systems of oppression, and specifically when examining systemic racism. Rather, this specific focus is to draw attention to and challenge the ongoing invisibilisation of Indigenous Peoples and their rights even in anti-racism, post-colonial and critical-race theory discourse that undermines the recognition and ensuing tension that all non-Indigenous Peoples have benefited from the legacy of land dispossession and colonization (Ward, 2018). This attention brings into focus the importance of concepts related to Indigeneity, sovereignty, our shared history of colonial violence, and land (Denzin et al., 2008; Lawrence & Dua, 2005)

d) What is needed to improve nursing's commitment and ability to disrupt anti-Indigenous racism, engage with social justice aims regarding Indigenous Peoples and, ultimately, engage with broader system changes to provide culturally safe care?

1.4 Significance/Purpose of the Research

The aim of this research is to investigate varying discourses and contexts that contribute to nursing's attitudes and behaviors in relation to Indigenous-led policies that mandate the adoption of Indigenous Cultural Safety and Humility to address systemic anti-Indigenous racism in healthcare and by extension, nursing. Examining these discourses offers insights into existing barriers for nursing to understand their role in addressing anti-Indigenous racism and explores solutions for nursing to action Indigenous Cultural Safety in a more comprehensive and meaningful way.

I love nursing. I entered nursing later in life with very little context about the nursing profession and, in fact, some of my understandings about nursing were erroneously informed by problematic public images of nursing that devalued and delegitimized the profession. On my first day of nursing school I knew, with every part of my being, that I was in the right place, and that the way in which nursing was presented to us was precisely in line with who I was and how I wanted to contribute to the world. Not only did nursing practice call to me, but the collective power nurses have to impact change and improve health for all areas of society inspired me to my core. The nursing community has shown me tremendous care and lifted me up in ways I never knew were possible. I am deeply grateful that I found nursing and that nursing is now a part of who I am.

As a nurse, I have practice experience in all five domains of nursing practice: clinical care, policy, education, research and administration (CNA, 2015). In all of these areas I have

witnessed and experienced anti-Indigenous racism in many forms--at a societal and systemic level, within organizations and in direct care. It has been painful to reconcile that the profession I care so deeply for is complicit with a complex system inextricably linked to ongoing colonialism and settler-colonial violence that targets Indigenous Peoples. My motivation for this research is to examine the ways in which nursing responds to systemic anti-Indigenous racism through critical discourse analysis in order to understand the dynamics that lead to action or inaction. My intention is not to "call out" nursing, but rather, to call in nursing to engage in critical self-reflection, healing and to inspire action for change. It is because I believe so deeply in the power of nursing that I engage in this work and research. In the words of Elder Gerry Oleman, "We cannot say goodbye to a problem until we first say hello" (Oleman, Indigenous Knowledge, personal communications, n.d.).

1.5 Background and Context: Socio-historical Political Perspectives of the History and Legacy of Colonization within Healthcare Contexts and Nursing

Nursing's engagement in addressing anti-Indigenous racism is informed by a complex tapestry of socio-historical contexts, professional identity and hegemonic relationships of power and privilege that both negatively impact nursing and are perpetuated by nursing. In the following sections, I provide a necessary socio-historical political overview of the legacy of colonization within healthcare contexts to illustrate how the social, cultural, and political agendas of colonization within Canada have informed nursing discourses and actions since contact and in ongoing colonization efforts. The sections that follow are intended to serve as background and context, and are structured based on the insights gained by reviewing the textual sources of Table 1 and the analysis of nursing discourse. I begin by providing the historical backdrop of colonization specifically within health care and nursing. I then examine how health care was

used as a tool for colonization and the ways this has impacted and informed nursing identity and discourse. Next, I examine how the legacy of colonialism is manifested in present day contexts in the form of anti-Indigenous racism and how this informs nursing identity, nursing discourse and nursing's response to addressing anti-Indigenous racism. Lastly, I discuss the impacts of ongoing colonization within the delivery and access of health care for Indigenous Peoples and the implications for nursing.

The methodologies that inform this thesis, as I will outlined in chapter two, are foundational in contextualizing the following sections that describe the socio-historical political perspectives of the history and legacy of colonization within nursing. Postcolonial perspectives and burgeoning writings by Indigenous scholars continue to emphasize the myriad ways that explicit anti-Indigenous racism was the impetus for and is the ongoing root cause of colonization, assimilation policies, and genocide. Within the healthcare sector, racism and ongoing colonization are consistently identified as the dominant factor underlying the health inequities experienced by Indigenous Peoples (Paradies et al. 2015; Reeding, 2013; Turpel-Lafond, 2020). Postcolonial analysis disrupts decontextualized healthcare discourses that pathologize Indigenous Peoples and render invisible the colonial legacy of subordination of Indigenous Peoples in Canada within health and nursing (Browne & Smye, 2002). Relational inquiry is an additional lens for critical analysis of nursing's positionality, power, and privilege within the systems of oppression manifested through the colonial legacy of healthcare in Canada's colonization agenda, which can support nursing's acknowledgement of its responsibilities in upholding the rights of Indigenous Peoples (Crosschild et al. 2021). I apply CDA to examine how discourses of anti-Indigenous racism within healthcare impact nursing. When analyzing discourse related to public policy, CDA is a useful methodology to highlight the

socio-political contexts that influence discourse (Smith, 2007) and, within this study specifically, to understand how nursing has engaged with and responded to the policy recommendations of Table 1: *Corpus of Discourse Data*.

1.5.1 Healthcare as a Tool for Colonization and Assimilation: Implications for Nursing

To deepen understandings of nursing's engagement with policies related to Indigenous Peoples, it is important to understand the extent to which health care is positioned in relation to the Canadian government's aims of colonization. The health care system was created by the colonial government and therefore has, in many contexts, been used within Canada as a system to colonize, assimilate, segregate and harm Indigenous Peoples (Allan & Smylie, 2015; McCallum et al., 2018). As indicated in the examples of Indigenous-led Policies and Reports as listed in Table 1, it is clear how significantly the healthcare system contributed to Canada's colonization agenda and the genocide of Indigenous Peoples when considering the policies and practices of governmental and institutional harm of the Indian Residential Schools System, Indian Hospitals, legislated forced and coerced sterilization, child apprehension using government sanctioned Birth Alerts in hospitals, Canadian funded medical experimentations, the attempted annihilation of Indigenous health and healing practices through legislated cultural bans, disruptions to access to healthcare services through the reserve system and the institutionalization of healthcare, the pass system, and the illegal forced dislocation of sovereign First Nations communities through land theft away from centralized health institutions. Throughout these government approved health institutions and means of harm that targeted Indigenous Peoples, nursing has been present in the management and delivery of systems. Since contact, nursing has been instrumental in advancing the colonization agenda of Canadian health care through acts of assimilation and the eradication of Indigenous health and healing systems

through the imposition of Western bio-medical supremacy. Examples of nursing's involvement in systems of harm that advanced colonization include the significant role nursing had in the Indian Residential School System, Indian Hospitals, the targeted child apprehension system of the mid to late 20th century, and forced sterilization (Symenuk et al. 2020). Nursing's origins within Canda are also deeply connected to the Christian church's missionary efforts and government public health agencies, which were the two major intitutions at the forefront of colonization and who were responsible for carrying out health related violence and harm. These colonial roots permeate nursing identity to this day. Nursing's legacy in this harm is often not acknowledged and remains largely unexamined by the nursing profession at large (Bell & van Daalen-Smith, 2021; Symenuk et al., 2020). Canadian nursing organizations and nursing scholarship have examined concepts of social justice, cultural safety and humility, equity and oppression; however, rarely do they explicitly name or examine anti-Indigenous racism, nor does nursing easily recognize itself as directly complicit in historical and ongoing colonization and systemic anti-Indigenous racism.

1.5.2 Locating the Problem: Anti-Indigenous Racism within Healthcare and Nursing

Dominant discourses concerning Indigenous Peoples health within settler-colonial states often frame health issues through a deficit lens, examining disparities as a moral failure related to health practices rather than examining health inequities within the context of systemic racism and colonization. Reading and Wein (2009) contend that the health inequities experienced by Indigenous Peoples exist within a broader socio-political landscape, and identify colonialism, racism, and social exclusion as a distal detriment of health that impacts Indigenous Peoples. Pervasive discourses within healthcare professions often compound the problem by intentionally or unintentionally pathologizing Indigenous Peoples by framing "Indigenous Health" initiatives

as supporting Indigenous Peoples in need of help, reinforcing notions of savioursim and paternalism in relation to care interventions. When healthcare organizations or institutions name "Indigenous Health" as a focus for care, it can inadvertently bolster the idea that it is Indigenous Peoples that have the health problem, when in reality, the source of health issues stem from systemic issues related to colonization, racism, and genocide. Bell (2021) describes pathologization as an instrument for racialized paternalism within healthcare systems that maintains the hegemonic status quo. For the purposes of this thesis, it must be made clear that the issue of focus is systemic anti-Indigenous racism.

The oral histories of Indigenous Peoples, documented in RCAP and the TRC as listed in Table 1, have widespread acknowledgement that Indigenous Peoples and communities experienced great health resulting from their holistic societal practices of wellness focused on emotional, spiritual, physical, and mental well-being. Findings from epidemiologists grounded in Western science have also determined that Indigenous populations worldwide had superlative overall health prior to colonization (Bezruchka, 2010). That is, the poor health outcomes and inequites Indigenous Peoples currently face in Canada are vastly different to their health pre-colinization. Since time immemorial, Indigenous Knowledge and holistic health practices have contributed to healthy Indigeneous communities and populations with a strong emphasis on overall wellbeing (Indigenous and Northern Affairs Canada, 2018). Colonization, the imposition of Eurocentric values, forced assimilation policies related to health practices, and genocide disrupted all facets of Indigenous health systems.

Despite the ongoing attention given to the health disparities impacting Indigenous Peoples, the dominant discourse in Canadian society rarely attributes these disparities to socio-political inequities correlated with ongoing colonization and systemic anti-Indigenous racism. In

contemporary health related contexts, many of these legacies of harm continue, as is now increasingly recognized in the most recent policy documents outlined in Table 1: *Corpus of Discourse Samples*. While recently published policy texts such as the *Truth and Reconciliation Final Report and 94 Calls to Action*, *Reclaiming Power and Place, Out of Sight: Interim report of the Sinclair Working Group,* and *In Plain Sight* report signal growing awareness of the impacts of systemic anti-Indigenous racism within healthcare, it is essential for nursing, as a discipline, to find ways to engage with and advance these policy directives in meaningful ways, both in healthcare as well as in the nursing profession. Nursing must recognize that the ongoing harm identified in the aforementioned Indigenous led reports is also a result of dominant discourses of anti-Indigenous racism that are prevalent in healthcare and nursing, stemming from harmful ideologies non-Indigenous people have formulated about Indigenous Peoples that are entrenched in colonial notions of superiority (Browne, 2005; Allan & Smylie, 2015).

1.5.3 The Impacts of Colonization on the Health of Indigenous Peoples

The history and legacy of colonial harm discussed above are the root cause of the health inequities identified in the various reports of Table 1: *Corpus of Discourse Data* and are also evidenced by population-based health studies that consistently find Indigenous Peoples in Canada as ranking lower that non-Indigenous peoples in life expectancy, income, education, access to housing, food security, and mental health (Canada, P.H.A.O., 2019; Chief Public Health Officer, 2016; Public Health Agency of Canada & Pan-Canadian Public Health Network, 2018). The opposite is also true, as seen in the First Nations Health Authority and Office of the Provincial Health Officer (2020) report that revealed that the disruption of colonial health systems, the reclamation of traditional health and healing practices, upholding First Nations self-determination in healthcare delivery, and implementing Indigenous cultural safety within bio-

medical healthcare systems interrupted negative data trends related to First Nations health outcomes in BC and was shown to reduce negative health impacts on First Nations Peoples. In a 2015 meta-analysis, racism is reported as being a significant indicator related to poor health and correlated with suicide ideation, planning, and attempts; post-traumatic stress disorder; overweight-related outcomes; and cardio-vascular disorders (Paradies et al., 215). International reports from the UN and NGO's have also signaled the need for immediate attention to address ongoing human rights violations towards Indigenous Peoples in Canada (Amnesty International, 2021; Canadian Human Rights Commission, 2021; Human Rights Watch, 2021; NWAC, 2022; UN General Assembly, 2014). These international reports can support nursing to examine health inequities through a rights-based lens, which is a core underpinning of the concept of cultural safety. Cultural safety, a key concept informing the theoretical perspective of this thesis, is an action-based approach to disrupting the inequities that impact Indigenous Peoples' health through the lens of social justice, sovereignty, and rights-based analysis. As I emphasize in this thesis, locating the key areas of harm that impact Indigenous Peoples through the application of cultural safety is critical to support nursing advocacy, practice, and policy efforts moving forward.

1.5.4 Ongoing Colonization: Segregated Healthcare Service Delivery for Indigenous Peoples

Since contact, Indigenous activists have advocated for social justice and reform of all social sectors within Canada with the healthcare system identified as a key area of harm. Globally, Canada remains one of the last countries to have segregated, race-based legislation that remains intact through the Indian Act, which was established in 1876, and continues to determine government imposed healthcare delivery for Indigenous Peoples to this day (Government of Canada, 2018). The legalities, processes, and implications of Canada's segregated healthcare

legislation for registered Indians under the Indian Act is poorly understood by Canadian healthcare providers and nursing. For decades, changing governments have promised healthcare reform in promoting Indigenous self-determination, and yet Canada continues to govern Indigenous healthcare delivery models with poor results. Recognizing that healthcare institutions and the overarching bio-medical model that sanctioned the health related atrocities aimed at Indigenous Peoples remain the foundation of our existing systems is critical when examining systemic anti- Indigenous racism. These colonial policies are inextricably linked with current bio-medical centric healthcare policies, institutions, and the professions that work within them. Not only does the colonial premise of the healthcare system remain in present day contexts, many of these systems are upheld through inherited healthcare policies and practices that maintain a status quo of oppression that negatively affect Indigenous Peoples' health. Nurses remain embeded in the colonial systems they work in, and as the largest segment of the health care workforce, they play a role in contributing to systemic anti-Indigenous racism and ongoing harm towards Indigenous Peoples as identified in the nursing policy documents and reports found in Table 1: *Corpus Discourse Data,* mostly released after 2020*:*

- (2013) BCNU's *Position Statement: Indigenous Health*
- (2014) *Aboriginal Health Nursing and Aboriginal Health: Charting Policy Direction for Nursing in Canada*
- (2015) CNSA's *Position Statement: Cultural Safety in the Context of Aboriginal Health in Nursing*
- (2016) *ARNBC Statement of Commitment on Aboriginal Health*
- (2020) NNPBC's *Commitment to Indigenous Health*
- (2021) CNA's *Nursing Declaration against Anti-Indigenous Racism in Healthcare*

- (2021) CASN's *Statement of Commitment Anti-Indigenous Racism*
- (2021) BCCNM's *Racism in Healthcare: An Apology to Indigenous Peoples and a Pledge to be Anti-Racist*
- (2021) BCCNM's *Commitment: Constructive Disruption To Indigenous-Specific Racism Amongst B.C. Nurses And Midwives*
- (2021) NNPBC's *Upholding the Truth and Reconciliation Recommendations*
- (2022) BCNU's *Bulletin: International Nurses Day: An apology to Indigenous Peoples*
- (n.d.) NNPBC's *Understanding Allyship*

All of these organizational documents summarized in Table 1 discuss or recognize to varying degrees that nursing has a role in the disruption of anti-Indigenous racsim either through their professional responsibilities and/or in recognition of the historical and ongoing ways nursing is complicit and part of a larger healthcare system that upholds systemic racism, which must be disrupted.

An integrative review published in 2022 highlighted key areas where nursing continues to participate in colonial harm, contributing to anti-Indigenous racism through lack of uptake of anti-racism pedagogy and lack of a critical examination of Canada and nursing's colonial history in relation to the current health disparities within nursing education; the prevalence of interpersonal anti-Indgienous racism between nurses and Indigenous patients and Indigenous nurse colleagues; and the lack of collective action to address systemic anti-Indigenous racsim within nursing organizations (Walizada et al., 2022). In these ways, nurses remain complicit in a complex system and legacy of a healthcare system that was founded on segragation by race, assimilation into bio-medical supremacy and, in many cases, the intended genocide of Indigenous Peoples.

Chapter 2: Theoretical Lens, Epistemological and Methodological Orientation

The aim of this study is to analyze dominant discourses informing nursing's engagement in addressing systemic forms of anti-Indigenous racism in Canadian led healthcare. The central questions asked in this thesis are the following: How does nursing as an organized discipline respond to anti-Indigenous racism in healthcare, specifically systemic racism as it manifests in relation to anti-Indigenous racism? In what ways does nursing respond to or engage with calls to action outlined in Indigenous led policies, legislation, and reports? What guides nursing's responses and actions in disrupting widespread inequities and systemic anti-Indigenous racism? What are the implications of these responses? What is needed to improve nursing's commitment and ability to disrupt anti-Indigenous racism, engage with social justice aims regarding Indigenous Peoples and, ultimately, engage with broader system changes to provide culturally safe care? A philosophical assumption underpinning the analysis of this research is that nursing has the motivation to disrupt systemic anti-Indigenous racism as well as an ethical and professional responsibility to do so.

In this chapter, I discuss the epistemological orientation of this study informed by both Indigenous Ways of Knowing and Western ways of knowing. I center Indigenous Ways of Knowing as supporting every component of this research, which includes Elder teachings and, as a core concept, cultural safety. Cultural safety is rooted in Indigenous nursing Knowledge and was established by Māori nurses to address anti-Indigenous racism within healthcare systems in Aotearoa, New Zealand (Bourque Bearskin, 2011). Cultural safety has since been adopted within the Canadian healthcare landscape due to its applicability within colonized states. I chose cultural safety as a core concept to inform this study due to its origins in Indigeneity and nursing

and for its relevance in addressing anti-Indigenous specific racism within healthcare systems. I also provide context and recognition of the paradox and tensions between Indigenous Knowledge and dominant epistemologies of nursing science that are used throughout this study. The tension described is not caused by the intricacies of Indigenous Knowledge, but rather, by its interpretation through dominant Eurocentric paradigms (Battiste, 2000).

I then outline the theoretical framework of this study, which is informed by critical discourse theory and the underpinnings of postcolonial nursing scholarship, and the aforementioned concept of cultural safety to inform the theoretical positioning of my research questions and the CDA lens. Postcolonial nursing scholarship is described by Browne et al. (2005) as a means to examine nursing's concern involving past and present colonization and issues of power and othering.

Lastly, I use CDA to analyze dominant discourses informing nursing's engagement in addressing anti-Indigenous racism in Canadian led healthcare. Language is an intrinsic part of our realities, and CDA offers researchers the ability to investigate hegemonic ideologies held in healthcare contexts specifically in relation to health inequities experienced by Indigenous Peoples (Fiske & Browne, 2006). Language is also hermeneutic in that it not only represents reality it also constitutes reality; therefore, nursing scholarship can greatly benefit from the critical inquiry of language to derive social meanings and relationships in the context of health (Boutain, 1999). CDA is used in this thesis to "focus on those features contributing to the fabric of discourse in which dominant ideologies are adopted or challenged, and in which competing and contradictory ideologies coexist" in the context of nursing's response to anti-Indigenous racism in healthcare (Tenorio, 2011). In this way, this study draws on policy statements, reports, nursing organizational language, and media presence as entry points for exploring and describing

the various discourses, contextual factors, and socio-political trends that influence nursing's actions to address anti-Indigenous racism. By critically examining nursing discourse through the lens of CDA, nursing positions itself to better disrupt dominant anti-Indigenous discourses within healthcare systems and the nursing profession to build safe, equitable healthcare services.

2.1 Epistemological Orientation

To begin discussions regarding the epistemological orientation of this thesis it is imperative to begin by identifying that this research is located within a Western-Eurocentric paradigm. In addition, the dominance of Western-Eurocentrism within all contexts of my graduate studies leading up to this research must be acknowledged, including but not limited to the teachings and curriculum of the UBC School of Nursing, the framework and format of this thesis, the majority of available references and supporting nursing scholarship, and the nursing knowledge that informs my mentors and supervisory committee. The hegemonic nature of Western-Eurocentric paradigms in academia broadly, and nursing as a discipline specifically, immediately locates Indigenous Knowledge as "other." While academic institutions and schools of nursing are working towards the inclusion of Indigenous Knowledge, it is important to note that the concept of inclusion contains challenges and can intentionally or unintentionally perpetuate paternalism, othering and tokenism. The current societal and institutional pressures to address longstanding inequities through mandates for Equity, Diversity and Inclusion (EDI) do not disrupt the power and positionality of institution but rather maintain the status quo by rendering racism and, by extension, Whiteness invisible (Walcott, 2019). The practice of including Indigenous Knowledge or Indigenous Ways of Knowing within Western academia and scholarship as a stand-alone action and un-accompanied by a critical exploration of power and privilege asserts and maintains the authority of Western ontologies over Indigenous ontologies

through cognitive imperialism (Crosschild et al., 2021). Stein (2017) describes the inclusion of epistemological differences as a means to diversify Eurocentric systems/institutions while maintaining Western-Euro-supremacy in an act of modern day colonialism. Ultimately, Western ontologies hold power and are privileged within these relationships, allowing for a system that may or may not uphold the inherit sovereignty or rights of Indigenous Peoples. Indigenous Peoples may be included in advisory roles, as consultants or as stakeholders; however, these relationships exist within systems that are hegemonic by design and structured to maintain White Western Eurocentric values and privilege, which sustains inequitable relationships. When referring to Whiteness in this context, the meaning is not in relation to socially constructed concepts of race related to skin colour, but rather, how Whiteness is perpetuated within society through its dominance and the establishment of White supremacy within socio-political norms and culture (Frankenberg 1993; Puzan, 2003).

An example of how systemic inequities manifest for individuals is the number of Indigenous scholars who must engage in additional labour to justify Indigenous Ways of Knowing or Indigenous Knowledge that may inform their research. Considering the sovereignty and rights held by Indigenous Peoples of this land, the need to justify Indigenous Knowledge systems is the result of ongoing colonization and racism. Another example is demonstrated in Western conceptualizations of professional currency and achievement of hierarchical status within the healthcare system. For example, my professional nursing aspirations are to advance the work of disrupting anti-Indigenous racism within the Canadian led healthcare system. In order to pursue these goals, I must complete graduate studies within the confines of a system that privileges and promotes Western-European knowledge and education. The course of study and

professional pursuits described above are not only privileged, they are the only option available within the nursing profession and the healthcare system within Canada. In this way, it is important to highlight that engaging in university-based graduate studies research is to participate in an ongoing process of present-day colonialism and assimilation because emancipation from these systems is not yet an option. Therefore, it is critical that approaches of resistance be explored and honoured to counter colonizing practices embedded throughout the research process in support of social justice. Kirkham and Browne (2006) describe a critical-theoretical orientation to social justice as a means to actively address inequities and injustices which are embedded within all levels of societal constructs and that continue to harm marginalized groups of people. The authors elaborate that in colonial contexts such as healthcare delivery within Canada it is critical to apply a postcolonial scholarship lens to social justice to account for the impacts of colonization and anti-Indigenous racism as a determinant of health (Kirkham & Browne, 2006).

Emancipation from epistemological hegemony will require active disinvestment from existing conditions within our systems and earnest engagement in creating co-meaning and shared value with different knowledge systems (Stein et al., 2020). Sinclaire et al. (2021) discuss the need to disrupt the hegemony, dominance and privileging of biomedically-based knowledge systems (and biomedically-based approaches to knowledge development) within nursing and their tendency to include Indigenous Knowledge as supplemental to Western knowledge, through the adoption of *Etuaptmumk* (Two-Eyed Seeing) and Ethical Space within health and nursing research. *Etuaptmumk* (Two-Eyed Seeing) and Ethical Space are Indigenous philosophical concepts that are grounded in relationships that co-create meaning without merging or leveraging

one knowledge system over another (Sinclaire et al., 2021). In this way, it is important to acknowledge that the emancipation from Western epistemologies is not to discredit the good that exists within these knowledge systems nor how it has supported the rigor of this research, but rather, to emphasize the impacts, limitations, and harm related to its dominance over Indigenous rights and Indigenous Knowledge systems.

2.2 Ontological Orientation

The ontological orientation of nursing that has informed this research is best described by Reed (1997), who perhaps unknowingly decolonizes nursing in her writings stating that nursing has been a way of knowing and being that "creates patterns of changing complexity and integration experienced as well-being in human systems" since time immemorial. Nursing's ways of knowing and "propensity for well-being" existed long before Nightingale and are timeless (Reed, 1997). In this way, a working assumption of this research is that nursing's ultimate concern is addressing the complexities of these human experiences, including the harm of racism, in pursuit of wellbeing in human systems. I am drawn to this world view of nursing due to its fundamental assumption that nursing is, and always has been, concerned with a greater harmony of health as a collective. Beyond the health of the individual, nursing cares for our collective humanity in pursuit of well-being for all people. The impacts of colonization and anti-Indigenous racism within Canada is a call to nursing to dismantle systems of oppression and restore wellness to our society.

While nursing is fundamentally concerned with supporting health, healing and wellbeing (Reed, 1997), in a contemporary context it is also deeply implicated in the matrix of White dominance and neo-colonialism. We are both influenced by, contribute to, and replicate White hegemony through the dominance of Whiteness, ongoing colonialism, anti-Indigenous racism

and bio-medical supremacy, and yet we are paradoxically charged with addressing the resulting harm. Rain Daniels, an Anishinaabekwe member of the Saugeen Nation, was a mentor to me when she served as a lead facilitator, trainer and mentor for the Provincial Health Services Authority San'yas Indigenous Cultural Safety Program[2]. In her teachings as my mentor, she shared an indispensable lesson with me cautioning dichotomized thinking and embracing a perspective that recognizes that "two truths can exist." This teaching has greatly informed my understanding of the complexities and paradoxical relationships that exist within nursing's identity and the "multiple truths" that contextualize nursing. This way of knowing moves away from dichotomies of good or bad, and rather, recognizes that nursing exists, and is informed by, competing factors within a complex healthcare system and social location. In this way, one "truth" is that nursing is complicit in systems of oppression in that Whiteness is embedded within nursing identity, and a second "truth" is that nursing is called to social justice and has an ethical responsibility to dismantle the oppression that nursing is also privileged by (Browne et al., 2023). Bourque-Bearskin (2011) sees this dissonance in the way nurses grapple with their inability to reconcile their values and nursing ethics within the hegemony and harm of the institutions they work within. It is this tension that nursing must contend with to inform nursing's role in disrupting anti-Indigenous racism and heal ongoing legacies of harm. I have personally grappled with and am consistently challenged by the tension I have as a mixed-ancestry, registered nurse working in a healthcare system that is actively contributing to and working against anti-Indigenous racism. While nursing's identity is complex and conflicting, it is nursing's propensity for social justice, Indigenous cultural safety and health equity that motivates

[2] San'yas Indigenous Cultural Safety Online Training (sanyas.ca)

my personal practice and informs this research to position nursing in its ongoing journey and uptake of Indigenous cultural safety within our profession.

2.3 Decolonizing Research

For the purposes of this research, viewing Indigenous Knowledge through the Eurocentric lens of empirical research models and to have it conform so that it fits into current epistemologies that guide nursing knowledge is a form of assimilation that is contrary to the beliefs and integrity of Indigenous Knowledge. This assimilation can unintentionally perpetuate the racism and eurocentrism that has excluded Indigenous Knowledge from nursing research in the past and present. The paradox described above must be acknowledged as a source of tension in this research so that the Indigenous Ways of Knowing that have informed this research are not lost. Indigenous Knowledge must be protected and validated based on the values and beliefs of its cultural roots and not be constrained by conforming to dominant Western-Eurocentric paradigms against the risk of extractive colonialism of Indigenous Knowledge (Drummond, 2020). In this way, the Indigenous Ways of Knowing that were imparted to me by Elders that have informed my research must be impenitently honoured and discussed as an autonomous way of informing this research. A key tenet of Indigenous nursing Knowledge is that it is grounded in one's identity, which is inextricably linked to knowing where one comes from and how this Knowledge informs one's nursing practice in relation to collective traditions to support health and wellness (Bearskin et al., 2016). Indigenous Ways of Knowing, being and doing must be valued and protected, in honour of and to fulfill the relational obligation each person has with the sovereign Indigenous Peoples whose land our work is performed on, including this nursing scholarship (Drummond, 2020). The following are stories of core teachings by three Elders that

have informed my nursing practice and research in addressing anti-Indigenous racism in healthcare.

2.3.1 Elder Teachings: Dr. Evelyn Voyageur

Elder Dr. Evelyn Voyageur is from Dzawada̲'enux̲w First Nation and is a retired nurse and the Elder-in-residence at North Island College where I completed my undergraduate studies in nursing. Elder Evelyn is a cherished mentor and has offered me countless teachings over the years that have guided me to become the nurse that I am today but, most importantly, she was there for me at the early stages of my racial identity work and supported me as I grappled with my Indigeneity and my identity as a nurse. One teaching in particular has provided me with the foundation to navigate the complexity of harm within anti-racism work that has been essential to my nursing practice.

Due to Dr. Elder Evelyn Voyageur and Dr. Joanna Frasers's incredible contributions to the nursing curriculum at North Island College, I was able to learn about the impacts of colonization within my nursing program and how neo-colonialism continues to impact Indigenous people's health. Having grown up within the colonized school system of Montreal, I had a limited understanding about the depth and complexities of assimilation, racism and colonization of Indigenous Peoples in Canada, including the impacts on my own family. It was only when I learned about the intentionality and ongoing violence of colonization in nursing school that I made the connections as to how this harm had a tremendous impact on my family and resulted in the erasure of, and many missing contexts related to, our Indigeneity. During this learning process, I had a pivotal conversation with Elder Evelyn that forever changed my perspective related to how I engage in anti-racism work. I came to her one day, distraught after

having watched the documentary *How a People Live* in our nursing class, which shared the story of the brutal dislocation of the Gwa'sala and the 'Nakwaxda'xw First Nations people from their homelands in 1964. I was profoundly upset by the recent violence and injustice shown in the film and by my increased understanding of the continued impact of harm faced by Indigenous Peoples, including my own grandmother. I was overcome by the seemingly irreparable legacy of this harm. As I cried in despair to Elder Evelyn that I could not see a way through the pain and violence nor imagine how these wrongs could be undone, she patiently and lovingly listened. When I was done, she told me that the work we have before us spans generations because the harm that has brought us to this moment in time has also spanned generations. She shared teachings that it would undoubtedly take generations to heal from our shared colonial pasts, but that this important work has been taken up by many generations before me. I was not to lose hope. She told me she has seen great change since she first became a nurse, and that the legacy of our work will contribute to important healing, so we must stay strong and persevere even when we feel hopeless. She reminded me that our ancestors are always guiding us and to look to them to find comfort and strength. Whenever I begin to feel that the challenges of this work are too great and that hate and racism are too strong to overcome, I remember Elder Evelyn's words. I remember her story and what she has overcome. I remember how much impact and change she has effected despite tremendous adversity and I continue the work of our ancestors with hope in my heart. Together, we continue to "change hearts and minds" (E. Voyageur, personal communication, 2013). *Gilakas'la*, Elder Evelyn.

2.3.2 Elder Teachings: Elder Gwen Campbell McArthur

Elder Gwen Campbell McArthur is of Ojibwe/Saulteaux Métis and Ukrainian Ancestry and practiced as a mental health nurse for more than five decades. Elder Gwen has been an

invaluable mentor to me and to many of my colleagues. Her teachings are numerous and profound. Elder Gwen has most notably taught me to always honour and stand in my truth.

For many years, I adopted practices that minimized my ways of being, thoughts and experiences in order to appease others, particularly in the context of anti-racism work. I had internalized many colonial practices and, without realizing, I often apologized for or avoided speaking my truth in an attempt to avoid conflict. Elder Gwen taught me that self-minimization in relation to my Indigeneity is a common response to navigate colonial violence and racism. I learned through her example and encouragement that speaking one's truth should never be minimized and that our Indigeneity is a constant source of contention to Canada. Elder Gwen showed me how the settler state is often judging us as the "good Indian," the "angry Indian," the "spiritual Indian," and many other archetypes as a way to dismiss, silence or reinforce behaviours that suit the colonial agenda. Elder Gwen's strength and sense of self is uncompromising. She grounds us all in the wisdom of knowing who we are, where we come from and honouring our authentic self. Elder Gwen grounds me in our traditions, teachings and connections to the land when I struggle in this work, and reminds me of who I am and the family ties that lift us up. While I still struggle to embody Gwen's courage, I grow each day and aim to have this research represent the Indigenous strength, wisdom and Knowledge she has imparted to me in unapologetic ways (G. Campbell McArthur, personal communication, n.d.). *Marsee*, Elder Gwen.

2.3.3 Elder Teaching: Elder Gerry Oleman

Elder Gerry Oleman is a member of the St'at'imc Nation from Tsal'alh and is a change agent and Elder for the Indigenous Health Department team at the Provincial Health Services Authority where I am currently employed. Elder Gerry has been instrumental in supporting my

personal and professional growth. During my training in the department, Elder Gerry provided our team of new hires with teachings to ground us in the mission of the work to address anti-Indigenous racism in healthcare systems. On the final day of our orientation, there was a closing check-in where we were invited to share our last thoughts. One concern that I shared was that even though I was extremely appreciative to be joining the Indigenous Health team and to begin work that directly disrupts anti-Indigenous racism, I was struggling in regards to my nursing identity because this new work was seen as outside the clinical setting, which is a central aspect of nursing practice for many nurses, including myself. I shared that my nursing practice was critically important to me and that I did not want to lose my nursing identity and the professional commitment I felt so strongly about, even though I believed that work to address systemic anti-Indigenous racism in healthcare was highly representative of nursing work. After listening to me, Elder Gerry told me that I need not worry about losing my nursing identity. He said what I always knew to be true--that nursing care heals, and that racism is in desperate need of that healing. He described the people and systems that perpetuate racism as sick. Elder Gerry instructed me to use my nursing knowledge to heal the world of racism. The teachings he gave me that describe racism as a hurt in need of healing was a call to action to me and to the nursing profession to take up this important work. I know that this also means that nursing must acknowledge its own complicity in colonial harm and must reconcile and heal its legacy of racism and colonization. Elder Gerry and I believe that nursing can take up this call to action and that the impact of this work will be immeasurable. As a nurse, I dedicate my nursing practice to the mission of the work to address anti-Indigenous racism within healthcare systems and dedicate this research to all nurses to head this call to action (G. Oleman, personal communication, 2018). *Kukwstum̓ckál̓ap*, Elder Gerry.

2.4 Theoretical Framework and Methodological Orientation

The nursing profession is an institution with its own identity informed by many factors, including societal values, culture, professional self-concept, work environments, and historical contexts (Hoeve et al., 2014). The nursing profession exists as a culmination of its members, meaning nurses, in service of people on their health journey. How we understand and constitute nursing is based on how the profession exists within the context of our society and is socially constructed in many ways. As a profession, nursing conducts itself through activity, policies, organizations, activism, scholarship, societal presence/influence and discourse. For the purposes of this thesis, I define nursing as the whole of this institution, inclusive of our organized discipline from a broad disciplinary perspective. The aim of this research is to understand the ways nursing, as an organized discipline, engages in addressing anti-Indigenous racism in Canadian led healthcare.

2.4.1 Critical Discourse Analysis

One way to understand phenomena is through language. The relationship between language and phenomena can be seen as informed by discourse and an understanding of social processes, including our institutional identities or even our reality, as constructed by discourse (Alvesson & Kärreman, 2011). Alvesson and Kärreman (2011) state that discourse not only reflects reality, it constructs it, meaning nursing "speaks" about itself through writing and language but those writings and language also inform how we "speak" about and, more importantly, understand nursing and its organizational reality. In this way, discourse can be used as an important tool to understand how nursing engages certain phenomena. In the context of this research, I use critical discourse analysis of nursing discourse to see how the institution operates in the disruption of anti-Indigenous racism.

Discourse is a perpetual relationship between the institutions and social constructs that formulate discourse and the discourse that in turn informs those same institutions and social constructs (Weiss & Wodak, 2003, p. 13). As socially consequential, discourse offers important insights into issues of power and, specifically, how it acts to reproduce power inequality through its representation of people in relation to institutions of power and vice versa (Fairclough & Wodack, 1997, p. 258). Critical discourse analysis finds meaning through critical reflections on discursive spaces to bring to the surface how ideologies are conceptualized and can perpetuate oppressive systems. In the case of nursing, discourses that nursing generates and contributes to (i.e., within the discipline of nursing, and in relation to the wider healthcare system) influence our identity and how we see ourselves in relation to our discipline, service, purpose and actions. At the same time, nursing's identity and how nursing has been conceptualized--internally within our own discipline and externally by society and social influences--shapes our discourse. Discourse informs our identity while our identity informs discourse. Critical discourse analysis examines discursive space to understand hegemonic power relationships affecting nursing, including those of colonialism, classism, racism, sexism, and other social influences. These lines of power both oppress and become a part of nursing identity and its actions. For this thesis, I use critical discourse analysis to examine key policy texts as an entry point for exploring and describing the various discourses, contextual factors, and socio-political trends that influence nursing's engagement with policies related to Indigenous Peoples' health.

2.4.2 Relational Inquiry

Another entry point for analyzing nursing discourse within this thesis is through relational inquiry. Relational inquiry is an approach that unpacks the complexities and interconnectedness of nursing practice in relationship with humanity and the world around us

through the process of inquiry (Doane & Varcoe, 2020, p. 13). Relational inquiry is an action orientated approach to nursing that aligns with the ontological orientation of this thesis in its assumption for nursing's primary concern for wellbeing while contextualized within the experiences between nurses, health care systems and socio-political/socio- historical contexts to more deeply examine how values, experiences, and structural contexts influence nurses and the nursing profession (Doane & Varcoe, 2020 pp. 2-5). Doane and Varcoe (2020) contend that nursing is inherently obligated to promote the well-being of patients, families, communities, nurses and the health system as a whole (pp. 20-22). CDA and relational inquiry both offer nursing a conceptualization of how we exist in the world as relational beings and, most notably, that we are simultaneously informed by and informing our relationships based on separate and mutual experiences. The parallels between CDA and relational inquiry can be linked to their theoretical foundations in hermeneutic phenomenology.

Hermeneutic phenomenology has influenced many domains of nursing (Earle, 2010), including relational inquiry, due to its usefulness in contextualizing how we as nurses are in relationship with patients, families, and community, allowing us to better understand how we make meaning and interpret our shared and individual lived and living experiences within the patient-nurse relationship, with the ultimate goal of supporting well-being (Doane & Varcoe, 2020, pp. 11-12). Relational inquiry applies a hermeneutic phenomenological lens to understand phenomena through the principal assumption that each person makes meaning by how they are situated and constituted in the world, which influences one's interpretation of the world around them, including one's relationship to another and how they understand each experience (Doane & Varcoe, 2020, pp. 42-49). Not only are we constituted and situated in and by our own social locations and experiences, but so too is the patient, and for the purposes of this thesis, nursing as

a whole. Nursing itself is situated within and constituted by social constructs related to many competing influences, and hermeneutic phenomenology provides an important lens through which nursing can examine how it is influenced and conceptualized by dominant discourses, normative values and practices and, perhaps most importantly, how these ideologies impact how we interpret and act in relation to ourselves and others (Doane & Varcoe, 2020, p. 42).

As with CDA, the foundational underpinnings of relational inquiry are not only in hermeneutic phenomenology but also critical social theory; these two theories complement the analytical process so that we not only make meaning of how we are in relationship with one another, but also analyze the dynamics of how normative ideologies of power and oppression impact these relationships. This study, and by extension my broader nursing praxis, is continually motivated and inspired by nursing's propensity for reflexivity and inquiry to inform nursing processes. I am continuously inspirited by nursing's relational way of being to understand our role within the holistic and healing relationship between patients, nursing, health and wellbeing. Informed by relational inquiry as an approach, the aim of this thesis is to support nursing as a collective to better understand how we are, as a profession, both impacted by and complicit in systems of oppression and power. Despite our complicity, we also have tremendous agency and a foundational obligation to disrupt inequities and harm in the promotion of wellbeing.

2.4.3 Postcolonial Nursing Scholarship

Postcolonial nursing scholarship supports the theoretical insights gained from CDA by examining the hegemony of past and present colonialism in the context of Canadian healthcare systems and the negative impacts this has on Indigenous Peoples' health (Browne et al., 2005). Postcolonial theory in nursing scholarship is particularly useful in examining nursing's role in

neocolonialism, colonization and racism in Canada to uncover how nursing is complicit within these systems and inadequately addresses issues of power through policy and social justice activism (Bickford, 2014; Kirkham et al., 2007; McGibbon et al., 2014; Reimer-Kirkham & Anderson 2002). Anderson (2000a) argues that postcolonial theory is necessary when engaging with healthcare policy change and reform to interrupt discursive practices that otherwise invisibilize systems of oppression. Anderson further contends that postcolonial theory is a critical paradigm for nursing inquiry because it provides direction for policy action grounded in social justice.

While postcolonial theory draws on Critical Race theory, it does not focus on any specific form of oppression, but rather, expands the lens to uncover the intersectionality of racism, sexism, colonialism, culturalism, colonization and more (Kirkham et al., 2007). According to Anderson (2000b), a postcolonial feminist perspective decolonizes nursing scholarship in its

> analytic power to illuminate how "cultural facts" are socially constructed and produced. New insights will mean deconstructing and rewriting taken-for-granted "knowledge," and redefining relations of power and privilege — one small step forward in a transformative agenda that embraces equity and social justice in the construction of knowledge for nursing practice in the twenty-first century. (p. 145)

Understanding the intersecting nature of critical perspectives is central in supporting nursing research aimed at addressing health inequities and advancing social justice within nursing practice. However, while many critical theories originate and continue to be located within Eurocentric paradigms, postcolonial theory calls on nursing research to emancipate from systems of oppression that often exclude IBPOC epistemologies within research discourse and to advance anti-racism and decolonizing research led by IBPOC scholarship (Reimer-Kirkham & Anderson,

2010). Foundational theories that support this thesis are, therefore grounded in postcolonial theory, to emancipate from colonized ideologies including the critical discourse analysis that aims to uncover hegemonic power systems and anti-Indigenous racism within healthcare systems and nursing.

Excluding postcolonial theory from the analysis of this research would risk centering Euro-Western knowledge to address issues affecting Indigenous Peoples that stem from Euro-Western centrism. In this way, it is important to note that while postcolonial theory is critical of colonial processes and power structures that Indigenous health inequities are attributed to, it is still a theory grounded in Eurocentric epistemologies and the framing of its title as "post"-colonial minimizes the ongoing presence of colonial systems that continue to marginalize and oppress Indigenous Peoples (Browne et al., 2005). Ahenakew (2016) uses grafting as an analogy to describe the tension of including Indigenous Knowledge within Eurocentric epistemologies:

> Grafting is used in biology as the process of transplanting something from one organism into another (e.g., hybrid plants or cell/skin implants). Grafting, in itself, is neither good nor bad. Indeed, hybridity can be a generative process. However, in the context of grafting into non-Indigenous ways of knowing, we are operating with severely uneven environments shaped by historical circumstances where the grafting/hybrid-izing does not happen as a mutual exercise, but as assimilation. Grafting, in this sense, can further contribute to the elimination of Indigenous peoples as distinct Indigenous peoples both in their relationship with the state, in their relation to the land, and in terms of the perceived worth of their knowledge. (p. 324)

Indigenous scholars such as Battiste (2000) argue the importance of emancipating completely from Western philosophies by giving space to Indigenous Knowledge and decolonizing

processes in order to truly enact the intent of postcolonial theories. Postcolonial Indigenous Knowledge extends beyond postcolonial theory to critique the colonial structures that house Western epistemologies and resists conforming Indigenous Knowledge in an attempt to "legitimize" Indigenous Ways of Knowing within a colonial framework (Battiste, 2000). Postcolonial theory and Indigenous Knowledge are central to this research and must be at the forefront of any action aimed at enhancing nursing's capacity to address anti-Indigenous racism within healthcare systems.

2.4.4 Cultural Safety

In addition to the above epistemological and theoretical underpinnings of this thesis, a core concept informing this research is the concept of cultural safety. Cultural safety was first introduced into nursing literature by Irihapeti Ramsden, an Indigenous nurse, and her extensive research on and advocacy for the subject remains the formative work of this concept (Ramsden, 1993). Cultural safety has been widely researched and adopted in New Zealand's government and healthcare systems, specifically in nursing education and policy (Ramsden, 1996). Due to the success of cultural safety in New Zealand and its origin in nursing, the ICN adopted the concept in 1995 as central to nursing practice and has since been taken up by nursing organizations around the world (Ramsden, 1996).

Cultural safety is defined as a nursing action that protects, reduces risk and promotes the health and wellbeing of a person's whole self in relation to their cultural values (Ramsden, 1993). Features that are inherent to the concept of cultural safety are social justice, de-colonization, health equity, anti-racism, Indigenous self-determination, relational practice, reflexivity, disruption of hegemonic power relations between nurses and Indigenous Peoples, and examination of colonial systems of oppression in relation to health and healing (Bourque

Bearskin, 2011; Dion Stout & Downey, 2006; Ramsden, 1993). Within Euro-Western paradigms, cultural safety is philosophically grounded in critical race theory, postcolonial feminist theory, and social justice (Bourque Bearskin, 2011; Browne et al., 2009). A main tenet of cultural safety is the specific focus on Indigenous social justice with the aims of de-colonizing healthcare systems to support safe services for Indigenous Peoples.

Canadian nursing scholarship has led the way for cultural safety to be adopted within Canadian healthcare contexts and other sectors where the parallels of colonial impact that colonized states have had on Indigenous Peoples' health are evident. Nurse researchers have identified cultural safety as an important lens for nursing scholarship given the history of research practices that have harmed Indigenous Peoples and appropriated Indigenous Knowledge (Browne et al., 2005).

Canadian nursing organizations provincially and nationally have recognized the importance of cultural safety and have adopted it in nursing policy and practice through professional practice standards, codes of ethics, education, research, and the work of nursing associations (Racine, 2014). More recent literature indicates a need shift our attention on cultural safety in nursing education to include a focus on adopting cultural safety within nursing practice for its ability to address anti-Indigenous racism and health inequities (Allan & Smylie, 2015; Browne, 2005): including assessing how Canadian health systems and nursing operationalize cultural safety in nursing practice (Dion Stout & Downey, 2006; Racine, 2014). Nursing's uptake of cultural safety is paramount in advancing social justice in healthcare contexts for Indigenous Peoples, including within the domain of research.

I have chosen cultural safety as a lens through which to consider how nursing is engaging with anti-Indigenous racism due to its widespread adoption within healthcare systems as a

primary means to improve safety and access for Indigenous patients. While the concept of cultural safety has been discussed extensively in nursing scholarship, more research is required in evaluating its application in nursing practice settings, examining strategies for knowledge translation for nurses in practice, and measuring current training practices in their ability to improve health outcomes for Indigenous Peoples. In this way, the concept of cultural safety informs discourse by the ways in which nursing does or does not take action to address anti-Indigenous racism or in how nursing conceptualizes and actions cultural safety. Lastly, I apply a cultural safety lens due to its origins in nursing and Indigenous nursing Knowledge with the goal to align this research with an Indigenous theoretical nursing lens. Cultural safety has been crucial in shifting nursing's consciousness in considering its own role in decolonization and upholding the rights of Indigenous Peoples.

2.5 Critical Discourse Analysis as a Method

There is considerable diversity in CDA approaches, and it can be taken up methodologically in a variety of ways. Meyer (2001) concludes that not only does CDA not have a prescriptive theoretical viewpoint, CDA is also influenced by a wide variety of epistemological theories, mid-range theories, and individual concepts found in larger theoretical traditions. The following is a proposed outline for how CDA is used as a methodological standpoint for the purposes of this thesis study.

Wodak (2015) describes CDA as a methodology that is in constant relationship, interconnecting theory, methods, and analysis (p. 14). The particular lens through which data are analyzed is never theory-neutral, and interpretation is informed by the theoretical perspective as concepts emerge and are systematically related (Wodak, 2015, p. 14). Procedures for CDA can be understood as a hermeneutic process in that "the meaning of one part can only be understood

in the context of the whole, but this in turn is only accessible from its component parts" (Wodak, 2015, p. 21). Weiss and Wodak (2003) emphasize the importance of critical discourse analysts employing rigorous personal reflexivity to examine how social and political locations are not separate from the research; this is to maintain the integrity of critical philosophies because "if critical analysts fail to be self-reflexive, then the critical enterprise can be compromised, to the extent that the critical limits of critique become ignored and thereby hidden" (p. 37). Widdowson (1995) argues that CDA is a contentious area of inquiry in that the bias of the analyst is unquestionably privileged in the critique. Critical theorists understand critique of hegemonic power relations not as a result of analysis, but rather, as the reason for analysis and, therefore, non-critical approaches can intentionally or unintentionally perpetuate dominant ideologies (Weiss & Wodak, 2003, p. 39). Smith (2007) states that in addition to acknowledging personal bias, it is important to maintain consistent methodological approaches to reduce bias; for this reason, I am transparent about my own inherent bias and also maintain consistent methodological practices throughout this research.

Wodak (2015) further describes CDA not as a method but rather an eclectic system of approaches connecting theoretical themes to analyze the data in relationship to social contexts (p. 21). The application of CDA begins with a research question aimed at understanding a discourse related problem through a specific theoretical lens and then analysis is conducted with numerous foci to examine hegemonic power relationships within broader social systems (Valderama-Wallace, 2017). The aims of this study are to critically analyze nursing's engagement with policy initiatives related to Indigenous Peoples' rights and health as represented through discourse. The discourse related problem within this study is focused on systemic anti-Indigenous racism and health inequities within healthcare contexts, recognizing that what occurs systemically shapes

nursing practice at point of care. While CDA does not recommend an explicit form of data collection, it does require a compilation of a corpus of discourse texts for analysis and theorizing with the aim of illuminating the discursive tenets of societal inequities (Wodak, 2015, pp. 21-22).

The data collected for this study were selected texts from across various organizations and institutions that inform, regulate, and guide nursing's professional obligations. These provincial, national, and international organizations represent four categories of nursing bodies that intersect to represent the nursing profession: nursing associations that act on behalf of the profession, nursing unions that act on behalf of the nursing work force, nursing regulators that act on behalf of the public, and schools of nursing that act on behalf of nursing education and scholarship. In addition to nursing texts, data also included reports, legislation, and declarations that reference nursing's obligations to uphold Indigenous rights in healthcare. Documents were reviewed with a focus on concepts related to systemic anti-Indigenous racism; health inequities; social justice; and particular manifestations of Indigenous Peoples' health, including the invisiblization of Indigenous Peoples, cultural safety, Indigenous Peoples' rights (with a specific concern for the right to access to healthcare), health and healthcare equity. These data were analyzed through the theoretical lens of critical discourse analysis, postcolonial nursing scholarship, and cultural safety to examine more broadly how nursing has engaged with the aforementioned concepts. In addition to the analysis of core concepts, further examination of power and connections to broader social contexts related to inequities with Indigenous Peoples' health and nursing are analyzed.

2.6 Ethical Considerations and Limitations

Data used for this study were solely in the form of publicly available texts. Therefore, no human subjects were involved in this research. Approval from UBC's Behavioural Research and Ethics Board was not necessary for this research due to the absence of interviews, observations, or the administration of questionnaires or tests on human participants. This study is of minimal risk due to the absence of human subjects.

Reflexive analysis of my racial identity, ethnocultural status, professional positioning, and privilege were considered in terms of bias and limitations of this study. An important ethical consideration regarding bias when employing CDA as a research methodology is to acknowledge overt personal biases in relation to the research; this includes disclosing professional identity such as nursing when analyzing phenomena within the discipline of nursing or healthcare policy (Smith, 2007). Due to my personal experiences, Indigeneity, mixed ancestry, and nursing practice experience in the domain of anti-racism training and healthcare policy addressing anti-Indigenous racism, my analysis is not without bias.

Chapter 3: How Discourse Analysis Expands Understandings of Nursing's Response to Anti-Indigenous Racism and Indigenous-Led Policies: An Analysis of Nursing Policies, Practices and Commitments

In this chapter I analyze how nursing is identified and discussed in Indigenous-led policy products, reports, and inquiries that have informed social and political action provincially and nationally to improve Indigenous rights in healthcare. I then provide analysis of how nursing as a profession has responded to anti-Indigenous racism in healthcare, including examining the implications of these responses, using a data corpus of textual sources identified in Table 1 that are organized into three sections: (a) provincial and federal mandates via legislation in relation to Indigenous rights;[3] (b) Indigenous-led reports and policy recommendations/calls to action; and (c) nursing policies, practices, and commitments that discuss, adopt, or address the aforementioned policy products and Indigenous cultural safety.[4] The textual data outlined in Table 1 are organizational documents analyzed from across provincial, national, and international organizations representing nursing associations, nursing unions, nursing regulators, and schools of nursing[5]. Lastly, I provide an analysis derived from the critical discourse analysis of nursing texts to examine the following research questions: How does nursing as an organized discipline respond to anti-Indigenous racism in healthcare, specifically systemic racism as it

[3] Data collection was limited to British Columbia (BC) because nursing practice is regulated provincially, and it is beyond the scope of this thesis to include all provinces and territories within Canada. Federal and National textual sources and policies that influenced or informed nursing practice within the province of BC were included.
[4] The concept of Indigenous Cultural Safety includes the disruption of anti-Indigenous racism and support of the rights of Indigenous Peoples.
[5] In support of the scope of analysis for this thesis, nursing organizations that do not strictly represent Indigenous nurses, such as the Canadian Indigenous Nursing Association, were examined in order to identify how non-Indigenous nursing organizations are responding to calls for action to address systemic anti-Indigenous racism and the impacts of settler colonialism within nursing.

manifests in relation to anti-Indigenous racism? In what ways does nursing respond to or engage with calls to action outlined in Indigenous-led policies, legislation, and reports? Guided by these research questions, I summarize the key themes identified from the analysis of the 23 organizational documents of textual data.

3.1 Nursing's Response to Anti- Indigenous Racism, Indigenous Activism, and Indigenous-Led Policies

In this section, I review the present day socio-political contexts that have impacted the uptake of addressing anti-Indigenous racism as an impetus for this thesis, and how nursing has responded to these events. I then review how the national and provincial government and Indigenous-led reports outlined in Table 1: *Corpus Discourse Data* identify nursing. Lastly, I review the nursing-led documents/texts in Table 1 to examine nursing policy action and discourse via the three pillars of the nursing profession--regulation, association, and unions.

3.1.1 Contemporary Examples of Systemic Anti-Indigenous Racism within Healthcare: An Entry Point for Analysis of Nursing's Response in the Face of Harm

The following analysis of contemporary examples of anti-Indigenous racism are part of the socio-political backdrop that has informed the textual sources analyzed in Table 1. The key examples identified below were the catalyst to the Indigenous-led activism that resulted in a surge of societal and government action which, in turn, influenced the nursing organizational texts used as data for the analysis of this thesis.

The impacts of racism have recently resurfaced in the consciousness of North American society following the death of George Floyd and the efforts of the Black Lives Matter Global Network organization, culminating in one of the largest human rights movements in recent history (Weine et al., 2020). The outcry from the public in the United States, Canada, and the

United Kingdom brought anti-black racism to the forefront of societal discourse. Global protests were led by the Black Lives Matter (BLM) movement with specific attention on systemic anti-Black racism within policing and calls to eradicate White supremacy, including state led and vigilante violence (Black Lives Matter, 2023). The BLM movement also occurred during the 2020 COVID-19 pandemic, when the cumulative stresses of the pandemic exacerbated existing interpersonal and societal violence and racism, which was unduly amplified by sanctioned discourses of racist rhetoric by many political leaders in positions of power at the time (Thorne, 2020). Two months after the death of George Floyd and the increase in public awareness of and concern regarding racism within the justice system and other colonial institutions, the BC government launched a thorough independent investigation into instances of racism, discrimination, and bias within BC's healthcare system. This investigation report summary, titled the *In Plain Sight Report,* followed accusations of specific instances of discrimination occurring in BC emergency departments. The review described the emerging social political context this way:

> This review has been conducted in a moment of increasing understanding about the colonial history of Canada and its enduring legacy, and the moment of transition we are in. Prejudice and racism against Indigenous Peoples have roots in colonial beliefs that Indigenous Peoples were weak, less worthy of care, dying off, incapable, savage, and primitive. These beliefs, embedded in laws and policies for more than a century, have shaped and continue to permeate public services such as health, education, justice, and child welfare. (Turpel-Lafond, 2020, p. 10)

The findings of the review were based on consultations with nearly 9,000 people, including Indigenous Peoples who accessed healthcare services in BC and healthcare providers from a

variety of practice settings concluding that widespread anti-Indigenous racism occurs within the BC healthcare system (Turpel-Lafond, 2020).

Within four months of the death of George Floyd and publication of the *In Plain Sight* report, in September 2020, Joyce Echaquan, an Atikamekw woman from Manawan, died while seeking care in a Quebec Hospital. Her medical concerns were ignored while she was subjected to racist mocking during a medical crisis, which she filmed just hours before her death. The final report of the investigation into Joyce Echaquan's death, identified anti-Indigenous systemic racism and prejudice as primary contributing factors (Kamel, 2020). Adding to the tragedy of Joyce Echequan's death was the reality that instances of Indigenous Peoples dying within Canada's healthcare system long preceded her particular case, as did calls for action to address systemic racism within healthcare to prevent further harm. The most notable example from a Canadian context is perhaps the case of Brian Sinclair. All too similar to the case of Joyce Echequan, Brian Sinclair, an Anishinaabe man, died from the impacts of racism and discrimination when he was ignored for 34 hours in a Manitoba Emergency room before dying of a common, treatable infection (McCallum et al., 2018). Three years prior to Joyce Echequan's death, the Brian Sinclair Working Group released the Out of Sight Interim Report (2017) on a decade-long investigation highlighting how racism, prejudice, discrimination, and ineffective accountability led to Mr. Sinclair's death and contribute to an ensuing legacy of injustice. In the case of Brian Sinclair, there were many systemic issues identified in the *Out of Sight Report* as having contributed to Mr. Sinclair's unnecessary death with many health care providers implicated including nursing. Despite the egregious findings of errors of neglect the Brian Sinclair Working Group (2017) found:

> Since Mr. Sinclair's death, not a single staff member or service provider received any disciplinary action in the workplace or from a professional governing body. Complaints made to the College of Registered Nurses of Manitoba were forwarded to the investigation Committee. They decided that in some cases no further action was required and in some cases they issued a letter of guidance to the member. None of the complaints were forwarded to by the Investigation Committee to the Discipline Committee. (p. 8).

This poignant example, demonstrates the systemic issues of anti-Indigenous racism within the health care system, including the nursing profession in this instance, manifested as an "indifference towards the unnatural deaths of Indigenous people" (Brian Sinclair Working Group, 2017, p. 1)

The climax of accumulated examples of violence and harm targeting racialized people, particularly within Canada's healthcare system, resulted in broader societal attention to anti-Indigenous racism, which led the federal government to conduct a series of meetings in 2021-2022 to discuss and develop strategies to address anti-Indigenous racism in healthcare (Browne et al., 2022). Many provincial and national nursing organizations attended these meetings to support these discussions and to develop their understanding of nursing's role in anti-racism efforts.

3.1.2 Indigenous Resistance and Rights: Examining How Nursing is Discussed in Indigenous-Led Reports, and Policies.

Reports and calls to action by Indigenous advocates are plentiful in reports, national inquiries, and changes in legislation from the last ten years alone, including, as listed in Table 1, the *BC's Declaration of Commitment on Cultural Safety and Humility in Health Services*, the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA), the 94 Calls to Action of the

Truth and Reconciliation Commission of Canada (TRC), *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, *Out of Sight: Interim Report of the Sinclair Working Group*, and *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Healthcare*. In addition to these recent reports, the *Royal Commission on Aboriginal People* (RCAP), established in 1991, was mandated by the Canadian Order in Council to examine Indigenous and Canadian relationships in response to ongoing Indigenous rights violations in Canada and was instrumental in garnering political support for the TRC. In this section, I apply CDA to specifically examine how nursing is discussed throughout these Indigenous-led provincial and national reports and their recommendations and/or calls to action.

Each report is divided into specific social categories and all of which are related to the social determinants of health, where nurses are implicated at every level. Arguably, every health related recommendation and call to action has implications for the nursing profession, given the broad scope of practice nursing holds in diverse positions across social sectors and as one of the largest civil service professions in Canada and the largest healthcare workforce (Symenuk et al., 2020). However, for the purposes of this thesis, only language that explicitly discusses nursing will be analyzed.

Within the 5-volume Report of *the Royal Commission on Aboriginal Peoples* (RCAP) (1996), the 6-volume final report of the *TRC* (2015), the 2-volume final report and executive summaries with calls for justice of *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (2019), the *Out of Sight: Interim Report of the Sinclair Working Group* (2017) and the *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Healthcare* (2020) are copious testimonies

and examples of harm where nursing practice and/or the nursing profession is complicit, along with recommendations to address this harm that are explicitly directed at the nursing profession. The key themes related to harm that categorically implicate nursing were these: withholding treatment, refusal of care and/or dismissal of patient concerns; examples of prejudice, discrimination, and anti-Indigenous racism in nursing practice; systemic anti-Indigenous racism perpetuated within the nursing profession and the healthcare system; and Indigenous Peoples identifying as feeling unsafe and mistrustful of nursing care (Brian Sinclair Working Group, 2017; Canada, 1997a; Canada, 1997b; Canada, 1997c; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019b; Turpel-Lafond, 2020; Truth and Reconciliation Commission of Canada, 2015a; Truth and Reconciliation Commission of Canada, 2015b).

Nursing was identified to varying degrees in the volumes of the TRC, RCAP and Reclaiming Power and Place that examined Canadian history in relation to the contemporary harm identified throughout the reports, which all discussed the significance of nursing's presence in Indian hospitals, the Indian Residential Schools systems, child welfare/apprehension and the role of nursing in missionary work and forced assimilation within the healthcare system (Canada, 1997a; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Truth and Reconciliation Commission of Canada, 2015a). The TRC identifies nursing's presence at all levels of the IRS system, including administration, as matrons, nurses, and educators. For example, in the TRC (2015a) *The History, Part 1 Origins to 1939*, it is recognized that the IRS system would not have existed without the work of nursing missionaries, stating:

> Their work would have been impossible without the support of a number of female religious orders. The Sisters of Charity (also known as the "Grey Nuns"), the Sisters of

> Providence, and the Sisters of Saint Anne, all Montréal-based female orders, provided the missions with teachers and nurses. By 1900, over 6,000 women were enrolled in these orders in Québec. (p.29)

The TRC also discusses nursing's relevance in the relationship between Indian hospitals and IRSs (Truth and Reconciliation Commission of Canada, 2015a). In addition to the presence of nursing with the IRS system, nursing care was also strategically withheld by government and the church to maintain unregulated authority over IRS operations. The TRC (2015a) *The History, Part 1 Origins to 1939* also identifies how Canada used nursing as a mechanism to discriminate against Indigenous children through limiting nursing care which was sanctioned by the church and government stating that "The churches were well aware of the problem of sick children (…) and objected to the sanitary inspection of the schools by government-appointed nurses" (p.417). During the tuberculosis (TB) outbreaks of the early 1900s, government appointed nurses working within the IRS system, had advocated that nursing services within the schools meet the professional nursing practice standards of the time but were denied because these standards of practice were seen as incongruent to "certain requirements essential to the proper training and discipline of Indian children" (TRC, 2015a, p. 417)

In addition to the *TRC*, nursing is also identified in the *Reclaiming Power and Place* report as a primary contributor to systemic assimilation through missionary work. There is further discussion of the powerful influence forced conversion to Christianity had in assimilating Indigenous Peoples in support of eradicating Indigenous Knowledge systems and traditional healing practices in favour of Western medicine (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Truth and Reconciliation Commission of Canada, 2015a). *RCAP* and the In Plain Sight Report noted additional historical harm related to systemic barriers

targeting the recruitment of Indigenous nurses caused by segregation and the disallowance of Indigenous nursing students within Canadian schools of nursing as well as inequities within pre-admission requirements (Canada, 1997b; Turpel-Lafond, 2020). There are also contemporary examples of harm discussed within several reports related to nursing care. For example, the *In Plain Sight Report* (2020) offers numerous examples where health care professional reported nurses racially discriminating against Indigenous patients where in one example there was "An Elder, who complained about her nurse, being left without hygiene support while the three other patients in her room were assisted to wash and bathe" (p.43), or where they heard "Indigenous residents talk about nurses pulling on their braids in the hospital, which is disrespectful; (…) comments about their "Indigenous sounding" names or appearances; and being told (…) that they get a free ride in society/into medicine (p.35). The final report of *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls Volume 2* (2019) also highlights how anti-Indigenous racism is implicated in the gaps in services that contribute to conditions that Indigenous Women are more likely to be harmed within society, with one example discussing racial discrimination in the form of lack of nursing care "A lot of people die from lack of care from the nurses who are not paying attention to their needs. Her mother had cancer for three months, and was just given Tylenol and sent home" (p. 132).

In addition to the harms outlined within the reports that discuss nursing explicitly, within each report, nursing is also identified in the calls to action and/or recommendations with three major themes emerging: 1) recommendations for nursing education, 2) recommendations to increase the nursing workforce and the recruitment and retention or Indigenous nurses and/or traditional healers, and 3) recommendations to increase accountability within nursing regulation

(Brian Sinclair Working Group, 2017; Canada, 1997c; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Turpel-Lafond., 2020; Truth and Reconciliation Commission of Canada, 2015b).

Nursing education is the most prominent theme within the recommendations with strategies focused on adopting content related to Indigenous cultural safety as a broad category. Call to Action #24 of the Truth and Reconciliation Commission of Canada (2015b) calls for nursing 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. (p. 3)

Call to action #24 of the TRC emphasizes the significance of adopting education specifically aimed at understanding Indigenous Rights to health and developing skills to eliminate discrimination in nursing care, however schools of nursing have yet to fully realize this goal. In the Yellowhead Institute *Calls to Action Accountability* report released in 2022, it is reported that "zero out of the seven Calls to Action in the area of health have been completed. In fact, what we've seen instead over the past seven years is piecemeal action" (p. 26). While nursing is implicated throughout the TRC health related calls to action, it is nursing's collective responsibility to ensure that any actions that specifically names nursing are enacted and it is unacceptable that nursing has yet to establish a concerted plan to enact Call to Action #24 almost 10 years after the TRC's release.

Similarly, Recommendation #4 of the *Out of Sight: Interim Report of the Sinclair Working Group* (2017) urges all health professional schools to "adopt anti-racism curriculum, and share best practices in relation to curriculum development with an emphasis on cultural safety for First Nations, Métis and Inuit communities" (p. 11). The most recent example discussing nursing education is found in the *In Plain Sight Report* in Recommendation 21 which states: "That all B.C. university and college degree and diploma programs for health practitioners include mandatory components to ensure all students receive accurate and detailed knowledge of Indigenous-specific racism, colonialism, trauma-informed practice, Indigenous health and wellness, and the requirement to provide service to meet the minimum standards in the *UN Declaration*." (p.64). The report then builds on this in Recommendation 23 advocating that the B.C. government, in partnerships with First Nations governing bodies and representative organizations, MNBC, Indigenous Nurses, experts and appropriate educational Institutions establish a "degree in Indigenous Nursing" and similar joint degree programs for nursing professions (p.65).

Building on the requirement for nursing education to adopt Indigenous cultural safety concepts into existing curriculum or as a separate pre-requisite course, the second theme called for increased recruitment and retention of Indigenous nurses and increasing the nursing workforce. The only recommendation in *RCAP*, Canada (1997c) that discussed nursing is 3.3.14 (1997b):

> to train 10,000 Aboriginal professionals over a 10-year period in health and social services, including medicine, nursing, mental health, psychology, social work, dentistry, nutrition, addictions, gerontology, public health, community development, planning, health administration, and other priority areas identified by Aboriginal people. (p. 202)

While nursing is identified among the many named healthcare professionals in *RCAP*'s recommendation 3.314 (1997b), the importance of the nursing workforce is identified in greater depth in *RCAP Volume 3*, *Perspective and Realities*, where community health nursing and workforce training is recognized as a key strategy for improving care for remote and rural communities (Canada, 1997b). *Volume 3* of the report goes on to describe that a leading challenge in closing the gap for Indigenous healthcare is the lack of continuity of care and relationship building in remote and rural communities (Canada, 1997b). Challenges in the recruitment and retention of Indigenous nurses in nursing programs and the profession are also identified. The recommendations to fund and target the nursing workforce was based on the ongoing lack of funding to pay for nursing resources in community and as a general lack of capacity within nursing stations, which were identified as the primary source of healthcare services for Indigenous communities (Canada, 1997b). Furthermore, nursing is described throughout the report findings as a key contributor in addressing inequities and gaps in access to care through community nursing and healing centers (Canada, 1997b). The *RCAP* commissioners, along with the Aboriginal Nursing Association of Canada (ANAC), now known as the Canadian Indigenous Nurses Association (CINA), identify in the report findings that the lack of disaggregated data to determine the number of Indigenous nurses within the Canadian workforce coupled with ongoing issues involving the recruitment and retention of Indigenous nurses was a major challenge. At the time of the report, less than 0.1% of the nursing workforce identified as Indigenous (Canada, 1997b). The report goes on to state that government resources were previously offered to ANAC, but the organization struggled to acquire consensus to develop strategies for implementing the use of traditional medicine for a primary care framework. Twenty-two years after the release of *RCAP*, Call to Action #23 of the *TRC*

reiterated the need for Indigenous nurses, calling for 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; and iii. Provide cultural competency training for all healthcare professionals” (p. 3). Recommendation #4 of *the Out of Sight: Interim Report of the Sinclair Working Group* (2017) also discusses the importance of increasing the number of Indigenous nurses, stating,

> schools must increase the number of visible First Nations, Métis and Inuit healthcare students, faculty and administrators and commit to anti-racist policies to improve the experience of all learners. Collaboration with continuing health education offices in the institutions offer excellent ways to address the ongoing behaviour and attitudinal changes that foster excellence in care for Indigenous patients in healthcare practices. (p. 11)

In a shift from the previous reports on how Indigenous healthcare providers and supports are conceptualized, *Reclaiming Power and Place* call #18.29 advocates for the creation of “roles for Indigenous care workers who would hold the same authority as community mental health nurses and social workers in terms of advocating for 2SLGBTQQIA clients and testifying in court as recognized professionals” p.217 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019b). This recommendation builds on the need to recruit Indigenous healthcare providers by also decolonizing these roles within health and healing initiatives. While this is the only call to action that explicitly discusses nursing within the final report of *Reclaiming Power and Place, National Inquiry into Missing and Murdered Indigenous Women and Girls* (2019b), nursing is implicated throughout the report in the health-related calls to action and are also in alignment with the key themes found in the other reports described in the core principles of the health related recommendations:

> • valuing wellness as wholeness, with a holistic understanding of safety and well-being, caring for mental, emotional, spiritual and physical needs;
> • using an interdisciplinary, systemic approach to coordinating services, rather than "silos" or forcing programs to compete against each other for funding;
> • understanding the importance of cultural safety, integrating Indigenous values and traditions in social services;
> • ongoing, mandatory training to equip frontline workers and management with the education necessary to engage with Indigenous communities in culturally safe ways; and
> • being able to build long-term, trusting relationships with service providers, including social workers, healthcare professionals, law enforcement, with continuity of care. (p. 50)

The *In Plain Sight Report*, (Turpel-Lafond, 2020) is one of the most recent reports in BC identifying the need for recruitment and retention strategies in recommendation #18 by calling on all educational programs for health professionals to "implement mandatory strategies and targets to identify, recruit and encourage Indigenous enrolment and graduation, including increasing the safety of the learning environment for Indigenous students" (p. 64). It also moves beyond adopting specific Indigenous Cultural Safety training within schools of nursing or formalized recruitment and retention strategies in recommendation #23 by calling for

> the BC government, in partnership with First Nations governing bodies and representative organizations, MNBC, Indigenous physicians, experts, and the University of British Columbia or other institutions as appropriate, establish a Joint Degree in Medicine and Indigenous Medicine. That the BC government, in partnership with First Nations governing bodies and representative organizations, MNBC, Indigenous nurses,

> experts, and appropriate educational institutions, establish a similar joint degree program for nursing professions. (p. 65)

This recommendation espouses decolonization as a process to create safe spaces within nursing education for Indigenous students while adopting Indigenous-led health and healing practices.

The final theme identified within the report recommendations focused on accountability in nursing regulation. Recommendations #4 and #8 of the *In Plain Sight Report* discuss the role of all health regulatory bodies, which would include BCCNM, to adopt professional practice standards involving Indigenous cultural safety and anti-racism practice, including improved processes for reporting and complaints to increase accountability for Indigenous cultural safety in nursing practice (Turpel-Lafond, 2020). Recommendation #3 of the *Out of Sight: Interim Report of the Brian Sinclair Working Group* (2017) has the most comprehensive language outlining strategies for nursing accountability, urging that

> unions and nursing and medical professional organizations issue clear and unequivocal position statements of zero tolerance for racism in the workplace. Further, mechanisms to receive complaints and concerns by Indigenous patients need to be adequately developed to eliminate and reduce the harm of racism at multiple levels, including in organizational policies and practices, and at the point of care. The nursing and medical colleges in Manitoba must develop processes to support positive behaviour changes by healthcare providers to foster equitable healthcare for Indigenous Peoples. Professional accountability and performance management strategies are needed to ensure that repeat actions of racism warrant severe disciplinary actions accordingly. (p. 11)

Recommendations aimed at supporting accountability within nursing regulation, improving complaints processes, and providing further clarity on nursing's responsibilities to enact cultural

safety within nursing's standards of professional practice are an important step to disrupt current harm that exists within the healthcare system.

In summary, despite the findings section of each report discussing nursing at length within various contexts historically and as the primary healthcare profession at point of care for Indigenous communities in rural and urban settings alike, nursing is not recognized nor identified as a key partner in broader policy initiatives within the recommendations and calls for action. While increasing the quantity and competencies of the nursing workforce are identified as targeted areas for improvement within the focused recommendations/calls to action, nursing is not identified as a contributor in influencing or strategizing overall healthcare policies and political action to improve healthcare services for Indigenous communities nor to address systemic anti-Indigenous racism within healthcare outside of an educational context. Nursing's framing within these documents stems and contributes to dominant discourses of nursing, where nursing continues to be perceived as a gendered profession, predominantly in point of care contexts, which highlights the importance of nursing associations and professional organizations' bolstering the presence of the nursing profession and its capacity within policy and political spaces in ongoing advocacy efforts.

3.2 Themes Identified from the Analysis

In reviewing the data, I examined how nursing responded to and discussed the reports, legislation, and declarations that reference nursing's obligations to uphold Indigenous rights in healthcare outlined in the *Underpinning Concepts and Recommended Actions* section in Table 1. In addition, the 23 organizational documents identified in Table 1 were analyzed to examine the nursing discourse of concepts related to systemic anti-Indigenous racism, health inequities, social justice, cultural safety and Indigenous Peoples' rights with a specific concern for the right to

access to healthcare. Through the analysis of the textual data of nursing organizational documents, three themes were identified in the findings. The first theme describes how nursing positions itself in relation to historical and ongoing harm and how nursing sees its role within this discourse. The second theme concerns nursing's predominantly aspirational engagement with such discourse and minimal frameworks for accountability. The third theme concerns the evolution of discourse in relation to Indigenous-led policy products and legislation in support of Indigenous rights.

3.2.1 Nursing's Relationship to Historical and Ongoing Systemic Anti-Indigenous Racism

The need to support cultural safety is based, in part, on the experiences of many Indigenous people with the mainstream health care system. Often these experiences have been negative due to cultural differences. Frequently, cultural differences and the inability of health providers to appropriately address these differences have contributed to high rates of noncompliance, reluctance to visit mainstream health facilities even when service is needed, and feelings of fear, disrespect and alienation. The first theme describes how nursing conceptualizes itself in relation to Indigenous Peoples' rights and discourse pertaining to nursing's role within this relationship. In the 23 organizational documents analyzed, nursing's focus was on cultural safety or concepts related to cultural safety along with recognition of the impact of colonial harm to the health and well-being of Indigenous Peoples. Indigenous health is discussed as a concept throughout the various documents and nursing as being dedicated to improving Indigenous health. In many of the documents, harm related to colonization and/or colonialism was discussed in the background section of the document to establish the context underlying nursing organizations' declaration of commitment to Indigenous cultural safety. While not all of the harm discussed was considered explicitly historical, there was extensive representation of harm

in the past tense and minimal articulation of how colonization is ongoing within healthcare and nursing nor how neo-colonialism is institutionalized within healthcare as a key perpetuator of continued harm. For example in the CNA's Position Statement on Promoting Cultural Competence in Nursing (2018) states:

> Cultural diversity has played a formative part in Canada's History. Originally inhabited by Indigenous Peoples, Canada has become a country of newcomers. The Immigration and Refugee Protection Act, Multiculturalism Act and the Charter of Rights and Freedoms have protected and encouraged freedom of cultural expression, making Canada the most diverse country of the G8. Canada is home to over 650 Indigenous communities, each possessing their own cultural principles and ways of knowing. Paternalistic government relations, and historical legacies, including the residential school system have influenced the core of Indigenous identity and negative impacted experience with the health-care system and Canada as a whole. The Truth and Reconciliation Commission and the process underway with the Indigenous Peoples of Canada marks an unprecedented moment in Canada's history, particularly the movement to improve relations through the commissions 94 "calls to action," of which 18-24 are specific to health. (p. 3)

In this statement, CNA begins by recognizing Canada's cultural diversity stating that Canada was "originally inhabited by Indigenous Peoples" and goes on to recognize the rights of Refugees and protecting multiculturalism. This sentiment reinforces ideologies that Indigenous people existed in the past and, unwittingly, implicitly erases the sovereignty and rights Indigenous peoples hold in Canada. While the following paragraph rightly goes on to recognize the 650 Indigenous communities within Canada, acknowledging the cultural diversity within

these communities and the "paternalistic government relations and historical legacy", it does not discuss nursing relationships in these contexts nor the ongoing ways in which the "historical legacy" is enacted via neo-colonialism. Lastly, when referencing the Calls to Action of the TRC, CNA does not discuss nursing's obligations to uphold these calls to actions but rather takes an aspirational approach to describe that the "process underway with Indigenous Peoples" marks an "unprecedented moment in Canadian History". How is nursing engaging or seeing itself in the "process underway"?

Documents published before 2020, as listed in Table 1 and seen in BCNU's *Position Statement Indigenous Health* (2013), BCCNM's *Declaration of Commitment of Cultural Safety and Cultural Humility* (2017), CNA's *Promoting Cultural Competence in Nursing* (2018), CNSA's *Positions Statement on Cultural Safety in the Context of Aboriginal Health in Nursing* (2015) and ICN's *Position Statement- Cultural and Linguistic Competence* (2013) are examples of how prior to the contemporary examples of systemic anti-Indigenous racism within healthcare and the ensuing social movements outlined in section 3.1.1, nursing discourse focused on the impacts of historical harm and nursing's commitment to cultural safety as a remedy to the legacy of that harm. CNSA's Position Statement titled Cultural Safety in the Context of Aboriginal Health in Nursing Education (2015) states:

> There is an ethical obligation to support reconciliation and restorative justice, leading to the improved health and right to self-governance of Aboriginal people, which is congruent with the Code of Ethics for Registered Nurses (Canadian Nurses Association, 2008; Mahara, Duncan, Whyte & Brown, 2011). Canadian nurses need to be aware of the unique context of Aboriginal people in order to provide adequate, culturally safe and competent care to promote the health of Aboriginal people. (p. 145)

While this position statement importantly describes nursing's ethical obligations towards reconciliation and includes concepts of restorative justice, it does not critically reflect what reconciliation and actions towards restorative justice would be for the nursing profession beyond adopting cultural safety. The position statement goes on to state that nursing "needs to be aware of the unique context of Aboriginal people", but does not discuss nursing this "unique context" as an obligation in upholding the rights of Indigenous peoples. CNSA positions cultural safety as a means to "promote the health of Aboriginal people" but does not locate nursing as complicit in ongoing structures of oppression that are at the root cause of what "cultural safe and competent care" are aimed at remedying.

Descriptions lack clarity in defining nursing's role within the adoption of cultural safety, including accountability for the nursing profession to enact cultural safety, nor was there a consistent definition of cultural safety as a guiding principle for the profession. As with the discourse analysis provided in section 3.1.2 ., regarding the limited discussion of nursing's agency and political influence within the various reports and Indigenous-led policy products, in the aforementioned documents, nursing further contributes to this discourse by not identify itself as a key influence and advocate within political and policy realms. Rather, nursing sees itself more as a passive observer of the system, arguing that indeed, harm has occurred, but nursing is at an arm's length to the broader social issues discussed. Nursing predominantly frames itself as an ally to advocacy efforts and not as perpetrator of historical harm. It also fails to identify systemic racism as ongoing within healthcare and nursing until after 2020. This can be seen in the language used in the BCNU (2013) Position Statement on Indigenous Health which states:

> As a society we have known for generations that Canada's Indigenous peoples are the sickest people in the country due to unnecessary inequities. As nurses and trusted health

> care providers, we must take the opportunity to change the status quo for a healthier Indigenous population. As a union, we will champion cultural competency and safety by supporting on-going education and raising awareness, both with our members and external partners, of issues vital to the health and well-being of Indigenous peoples. (p.4)

The implication of describing "society" verses nurses as knowing about the impacts of health inequities in this position statement, moves responsibility away from nursing complicity when discussing harms, however nurses are later described as "trusted health care providers" who must "take the opportunity to change the status quo for a healthier Indigenous population" and "champion cultural competence and safety" when discussing actions moving forward. The savourism and paternalism discourses within this sentiment, juxtaposed with the deficit description of Indigenous Peoples as the "sickest people in the country", positions nursing as not being involved in the harm but rather as an ally to outside influences of inequities. Lastly, BCNU like many organizations, states that nursing must rightly "champion" cultural competency and safety but lacks the strong political will the union typically displays in its description of how this will be enacted in policy and practices for nursing specifically.

3.2.2 Nursing's Engagement with Accountability Measures to Address Anti-Indigenous Racism

The second theme within the discourse is the aspirational nature of nursing's engagement with and commitments to Indigenous cultural safety and limited information regarding accountability measures to action cultural safety. CNA's 2017 *Code of Ethics* is a critical example of how nursing discourse is largely silent on issues of racism and anti-Indigenous racism despite it being foregrounded by *UNDRIP*, *RCAP*, the *TRC*, and the death of Brian Sinclair. The *Code of Ethics* for Registered Nurses highlights the important role nurses have in

ensuring healthcare policies are in line with ethical practices and, when policies, laws, or practice are not in alignment with our ethical obligations, our code can be a powerful political instrument for nursing advocacy in policy. While the code touches on the possibilities of its use in nursing policy, it does not clearly articulate nursing's role, mandate or ethical obligation to social justice and specifically cultural safety in addressing anti-Indigenous racism (Tisdale & Symenuk, 2020). The CNA *Code of Ethics for Registered Nurses* (2017) makes reference to nursing's ethical obligations towards Indigenous Peoples, stating, "Nurses respect the special history and interests of Indigenous Peoples as articulated in the Truth and Reconciliation Commission of Canada's (TRC) *Calls to Action* (2012)", and "Calling on all levels of government to acknowledge the current state of Indigenous health in Canada and to implement healthcare rights and take actions with Indigenous People to improve their health services (TRC, 2015)". While this new language adopted for the first time in the 2017 code is an important step forward for nursing, it also highlights how nursing discourse prior to 2015 was largely silent on issues of Indigenous rights. It was only after the release of the TRC in 2015, did nursing markedly implement language pertaining to Indigenous Peoples' rights to health, this despite the recommendations outlined in RCAP, the formal recognition of Aboriginal rights to health outlined in Section 35 of the Constitution Act of 1982, and the significant body of extant research regarding the impacts of health inequities on Indigenous Peoples within Canada, much of which was led by nursing scholarship. In the CNA (2017) code, nursing is "calling on all levels of government" to action Indigenous rights to healthcare, but notably, nursing does not name itself. While CNA certainly has a mandate to act on behalf of the profession to advocate for healthcare policy and action, including engaging with government, this example of language calling on government reinforces the discourse that nurses see themselves as advocates for and allies to Indigenous Peoples'

health, but do not articulate nursing's obligation within this collective work. In the 2017 code, nursing does articulate its ethical obligation to "respect the special history and interests of Indigenous Peoples." However, it does not convey that this is a shared history between the settler state and Indigenous Peoples and the "special interests" described are, in fact, rights.

The current CNA code does not meaningfully articulate nursing's ethical obligations to enact Indigenous cultural safety in practice--a nursing concept widely used at the time--nor nursing's obligations to uphold rights, address inequities, and stop ongoing harm in the form of anti-Indigenous racism. In this way, this analysis of discourse, which mirrors the majority of discourse in the organizational documents analyzed, shows that the nursing profession does not adequately understand its obligations to treaties and upholding the rights of Indigenous Peoples. It also fails to recognize the significance of Indigenous Peoples as sovereign to these lands, how this fact extends to Indigenous rights to healthcare, and that these rights exist beyond colonial-settler government.

Like CNA's code of ethics, the majority of the organizational documents analyzed were aspirational in sentiment in the form of an issues brief, declaration of commitment, or position statement. Most of the organizational documents from the *Corpus of Discourse* Table 1 were obtained through the various provincial and national nursing organizational websites, where organizations described their commitment to Indigenous cultural safety and, post 2020, a commitment to anti-racism; many texts explicitly specify anti-Indigenous racism as a target, which is an important shift in discourse. While these policy products hold significance in highlighting nursing's recognition of the importance of supporting the health of Indigenous Peoples, including the adoption of Indigenous cultural safety within nursing, and more recently addressing anti-Indigenous racism within healthcare overall, the wording is weak in agency and

is missing language regarding several crucial matters: 1) nursing's obligation to address anti-Indigenous racism as a profession and not only healthcare's; 2) strategies and frameworks to enact and track nursing's efforts to disrupt anti-Indigenous racism and action Indigenous cultural safety; and 3) recognition of the rights of Indigenous Peoples within healthcare and nursing's political and professional role in upholding these rights.

Within the organizational documents analyzed, the most comprehensive and robust body of work on Indigenous cultural safety on behalf of a nursing organization was conducted by BCCNM, which had a political mandate within the province to uphold DRIPA and the recommendations of the *In Plain Sight* report. As noted in Table 1: *Corpus of Discourse Data*, BCCNM policy documents were released starting in 2021, first in the form of a commitment to address anti-Indigenous racism, *BCCNM's Commitment: Constructive disruption to Indigenous-specific racism amongst BC Nurses and Midwives,* which outlined a comprehensive action plan and processes for accountability; then in an immediate follow-up to one of the objectives outlined in the action plan, which was tied to BCNM's commitment document: an apology released on behalf of nurses in the province, *Racism in Healthcare: An Apology to Indigenous Peoples and a Pledge to be Anti-Racist*; and lastly, in the implementation of a practice standard, *Indigenous Cultural Safety, Cultural Humility and Anti-Racism practice standard*, which was accompanied by a companion list of resource and tools available to nurses and organizations aimed at improving complaints processes and enacting Indigenous cultural safety within nursing regulation in BC. Indeed, in the province of BC, the Western-most province in Canada, cultural safety has been the key entry point for declaring nursing's professional commitments to confronting anti-Indigenous racism, including the health inequities and gaps in services impacting Indigenous Peoples. Nursing in BC is leading the country in terms of Indigenous

cultural safety and nursing's obligation to address systemic anti-Indigenous racism, a fact connected to broader socio-political contexts present in the province of BC.

Prior to the release of the findings from the *In Plain Sight* inquiry and the ensuing BC Ministry of Health's mandates that also coincided with BC's adoption of UNDRIP within provincial legislation through the DRIPA action plan, BCCNM was relatively silent on issues of anti-Indigenous racism and complaints of racism. Before the *In Plain Sight* report, regulatory bodies within BC, including BCCNM, recognized the value of cultural safety and cultural humility as seen in the *Declaration of Commitment of Cultural Safety and Cultural Humility* (2015), which was signed by all of BC's health regulators and each of the BC health authorities following the calls to action of the *TRC*; however, they did not recognize the lack of safety in complaints processes nor the magnitude of harm identified by the 9000 Indigenous Peoples and healthcare providers who came forward to be interviewed through the inquiry process. The provincial mandates imposed on BC health regulators to address anti-Indigenous racism within BC's health care system and the harm uncovered in the *In Plain Sight* report were the catalyst for action by BCCNM. As of the writing of this thesis, BCCNM has championed Indigenous cultural safety work amongst BC's health regulators and set standards provincially. In BCCNM's *Racism in Healthcare: An Apology to Indigenous Peoples and a Pledge to be Anti-Racist*, the college also recognized that regulators in BC were not engaged in dismantling racism within BC prior to the *In Plain Sight* report, and that the public was harmed as a result. While cultural safety and anti-racism efforts are occurring within nursing regulation in BC at the time of the writing of this thesis, the Canadian organization for nurse regulators (CCRNR) has no evidence of action on their website or within their publicly accessible organizational documents.

3.2.3 The Evolution of Nursing Discourse towards Indigenous-Led Policy Products, Legislation and Rights

The third theme revealed by analysis of the Table 1 texts is the evolution of discourse over time in relation to the Indigenous-led policy products and legislation in support of Indigenous Peoples' rights. Over the last 20 years, there is a marked progression in the discourse of concepts within nursing organizations, from cultural competency and cultural awareness to cultural safety, anti-racism, and social justice. BCNU was the first to engage to use this language in the establishment of the *Indigenous Leadership Circle* in 2005, followed by CNA and its *Promoting Cultural Competence in Nursing* in 2010 (updated in 2018), and then by BCNU again with its 2013 *Position Statement: Indigenous Health*, and finally, by ICN's 2013 *Position Statement*: *Cultural and Linguistic Competence.* These earlier documents focus on cultural competence and cultural awareness, whereas during the era of the *TRC* release, there is a shift towards the concepts of cultural safety, cultural humility, and equity. Interestingly, ICN's document does not reference Indigenous Peoples specifically, but rather, discusses cultural competence from a multicultural lens stemming from many of the key concepts found within cultural safety but omitting Indigenous Peoples entirely and applying cultural competence to pan all patient populations. Most of the nursing organization documents in Table 1 were released within the *TRC* era beginning with the 2016 ARNBC[6] *Statement of Commitment on Aboriginal Health* (see Appendix A) which was one of the first and only examples of a provincial nursing association to recognize nursing's obligations to address Indigenous health inequities and

[6] ARNBC was the former association representing registered nurses in BC until the amalgamation of BC's four distinct nursing designations into one united provincial nursing association now known as NNPBC.

establish Indigenous nursing leadership within BC's nursing association. Subsequently, after the human rights movement of 2020, nursing has re-engaged with new nursing organizational documents, entailing a distinct shift in discourse toward anti-racism efforts, addressing anti-Indigenous racism specifically and, in some instances, towards rights based discourse concerning Indigenous Peoples. None of the nursing documents analyzed in the *Corpus of Discourse* discuss *RCAP*, and very few discuss *UNDRIP*, *Reclaiming Power and Place*, and *Out of Sight: Interim report of the Sinclair Working Group* or *Joyce's Principle*; most focus on the *TRC* calls to action when referencing Indigenous-led policies or reports. Within BC, post 2020, when nursing organizational documents do discuss Indigenous-led health policies, they predominately reference *UNDRIP* or *DRIPA* and the *In Plain Sight* report.

3.3 Conclusion

These finding offer insights and opportunity for further exploration to understand nursing's commitment and engagement with Indigenous cultural safety efforts. It is critical that nursing understands what inhibits and what enables its ability to address ongoing systemic anti-Indigenous racism. As a powerful collective within the healthcare system, nursing has a professional obligation to uncover the ways it has been historically and contemporarily engaged in ongoing assimilation and oppression of Indigenous Peoples within Canada, how nursing is situated in the larger socio-political systems of Canada and, most importantly, how nursing can disrupt these patterns to see Indigenous cultural safety fully actualized within Canada's healthcare system and within our profession.

Chapter 4: Discussion and Implications

The following chapter describes nursing's challenge in locating itself as a contributor to harm and as complicit in ongoing colonization through the delivery of colonial care models designed to support assimilation and founded on eurocentric bio-medical supremacy that acts as a barrier to nurses' addressing systemic anti-Indigneous racism and ongoing colonization within healthcare. Nursing's apparent lack of understanding (and action) around its complicity in colonization is amplified by nursing's challenge to appreciate its agency in distrupting systems of harm and influence on Canadian healthcare policy and politics as well as its role in advancing the adoption of Indigenous-led health related policies and anti-racism movements. These factors culminate into harmful inaction and the problematic absence of nursing discourse and action regarding instances of anti-Indigenous racism in healthcare.

4.1 Does the Remedy Match the Harm

> There can be no imagining too radical, nor action too disruptive, when correcting course towards anti-racism, justice, and equity. Who and what is being privileged by tepid, tentative, and time-limited efforts? What is behind the incremental change we are witnessing? Is it fear? Is it nostalgia? Is it White supremacy sustaining itself? What are we protecting, if not everybody, if not every *body*? (Bell & van Daalen-Smith, 2021, p. 3)

Despite the overwhelming body of evidence and tangible calls to actions outlined in the texts of Table 1, the response from nursing organizations, including nursing regulatory bodies, professional associations, unions, and educational institutions has been minimal until recently and remains significantly disproportionate to the impacts of harm. Nursing has long been aware of the health inequities impacting Indigenous Peoples in Canada. Smye and Browne (2002) highighted over 20 years ago that nurses from all domains of nursing practice must engage in

health policy to build cultural safety within the Canadian healthcare landscape. Not only have nursing scholars been sounding the alarms and in many cases leading the research to identify racism as the primary issue concerning Indigenous Peoples' health, cultural safety is inherently an Indigenous nursing concept and one that has been championed by nursing, both Indigenous and non-Indigenous, within healthcare contexts in settler societies grappling with the impacts of colonization and colonial violence. There is no shortage of research or evidence of the ongoing and life limiting impacts of anti-Indigenous racism in healthcare settings, which unequivocally implicates nursing (as cited earlier, see for example, the *TRC, Reclaiming Power and Place the final Report for MMIWG Report*, the *In Plain Sight Report* and the *Out of Sight Report: Interim report of the Sinclair Working Group*). Given the evidence of harm outlined in section 3.1, both in contemporary and historical contexts, nursing's recent lack of visible engagement and public discourse in response to the culmination of publicized atrocities of anti-Indigenous racism in healthcare setting involving nurses is reprehensible. Following the publicized death of Brian Sinclair and Joyce Echaquan, what were the ways in which nursing as an organized discipline and regulated health profession responded? While there were isolated instances of outputs that constituted responses to the harm, overall, there was a significant silence and lack of outrage on behalf of the nursing profession.

Indigenous health advocate, Harlen Pruden (nēhiyo/First Nations Cree, Indigenous Knowledge, personal communication, September, 2019) shared teachings on the incongruity between the colonial harm of anti-Indigenous racism and the actions taken to address this harm stating, "The remedy must match the harm." He used the analogy that if a patient presented to an emergency room with a compound leg fracture, we would not treat the wound with a band-aid. In this way, Pruden asserts that the egregious impacts of centuries of colonial harm and anti-

Indigenous racism within our healthcare systems must be matched with the appropriate level of remedy to heal the wounds of racism. Do our current remedies match the harm? Pruden states, "We have not yet seen the immediacy, magnitude and collective response necessary to do this work." The extensive body of work that exists as a framework to guide nursing practice and policy to act against anti-Indigenous racism is overwhelming and yet, inaction and silence, except in the form of recent intention statements (e.g., from the BCCNM), is the most common response.

Understanding wider socio-political discourses on anti-Indigenous racism and how they inform nursing practice within healthcare contexts and, more precisely, contribute to discriminatory policies and practcies that harm Indigneous Peoples accessing care, is critical in determining how nursing engages in anti-racism efforts (Browne, 2017). Nursing is not a neutral entity within society, but rather, is constituted by and situated within neo-liberal ideologies that mask the hegemonic structures of hetero-patricarchal and colonizing systems (Browne, 2001; Smith & Foth, 2021). Kendi (2019) describes racism within settler society as a socialized consturct embedded within systems and our collective conciousness; in this way, Kendi asserts every person within society exists within and enacts systemic racism, and the duality that allows a person to be considered racist or not-racist is false (p. 236). Kendi also states that "The heartbeat of being racist is denial," where denial works as a powerful tool that upholds White supremacy and renders invisible the opression brought through systemic racism (p. 154). Whithin nursing discourse, the denial of racism is closely tied to notions of benevolence, morality, innocence, and virtuousness, all of which are embedded within nursing identity, and is used by nursing and against nursing to perpetuate the discourse that nursing cannot be complicit in enacting anti-Indigenous racism (Bell & van Daalen-Smith, 2021; Symenuk et al., 2020).

Gebhard et al. (2022) discuss the ways in which White benevolence is used in the helping professions as a means to perpetuate false discourses that Indigenous Peoples need saving and are in deficit, which upholds the institution of nursing and the supremacy of White behaviours of saviourism that invisiblize ongoing colonization and nursing's complicity in its violence. As seen in many of the organizational texts of the *Corpus Discourse* in Table 1, when nursing does acknowledge the existence of anti-Indigenous racism within healthcare, it rarely positions itself as a contributor, describing nursing instead as committed to advocating against this harm with minimal accountability, policy, or process aimed at the nursing profession.

A working assumption of this thesis is that the manifestation of denial through the absence of nursing discourse on issues of anti-Indigenous racism does not necessarily reflect a lack of care on behalf of nursing, but rather, a manifestation of privilege. This is often not an intentional or conscious denial of racism; it is a phenomenon of privilege based on Whiteness, that can be challenging for nursing to recognize. According to Puzan (2003), Whiteness exists within nursing not as a category of skin colour alone, but rather, informs nursing's social and political identity historically and in ongoing ways, including how new nurses (White and racialized) are assimilated into the hegemonic nature of nursing through behaviours, practices, and protocols. Bell (2021) uses socioculutral identity theory to examine how nursing identity informs collective professional activity and action:

> This leads to a monolithic, apolitical representation of nursing identity that erases difference, denies historical influence, universalizes nursing work and further marginalizes marginalized identities. The oppressive and hegemonic nature of a universal nursing identity may contribute to a lack of disciplinary reflexivity about the ongoing

influences of foundational discursive constructs of gender, epistemology, power and professional status. (p. 1)

Another working assumption of this thesis is that nursing both benefits from systemic racism and White privilege and also wants to dismantle it. Leaning into hard truths and engaging in reflexivity as a collective is imperative to actioning anti-racism. Indeed, this is the discomfort that comes from the ontological disruption of our collective professional identity, a discomfort that cannot take precedence over the oppression of a people.

Denial of White privilege can also be seen in the minimization or invisibilization of Indigeneity. An example of this appears within the discourse defining cultural safety as a concept within the nursing organizational documents analyzed in this thesis. As discussed in Chapter 2 section 2.4.4, cultural safety as a concept derives from Indigenous nursing Knowledge and scholarship, and was introduced into nursing practice in the 1980s. Its application in Australian and Canadian healthcare contexts has shown great results (Huria et al., 2014; Milne et al., 2016). Cultural safety originated from Māori nurses in New Zealand and was adopted by the Canadian healthcare system to address the health inequities experienced by Indigenous Peoples through a social justice, equity, and a decolonizing lens and derived its philosophical underpinnings from critical race and postcolonial theory (Bourque Bearskin, 2011). Dr. Ramsden (1996), the Indigenous nurse scholar who founded the concept of cultural safety, warned the nursing community of the negative implications of making adaptations or altering cultural safety on the basis that the concept may thereby lose its desired purpose to dismantle systemic racism in relation to power inequities stemming from colonization. As seen in CNA's *Promoting Cultural Competence in Nursing* (2018), and ICN's (2013) *Position Statement*: *Cultural and Linguistic Competence*, the concept of cultural safety and cultural competence are used interchangeably,

and the dominant discourse by which these concepts are identified in these texts are that cultural safety is aimed at providing high quality, safe, and equitable nursing care for all. In the ICN (2013) *Position Statement*: *Cultural and Linguistic Competence*, Indigeneity is not discussed at all, and in the CNA (2018) *Position Statement*: *Promoting Cultural Competence in Nursing*, the term cultural safety is recognized as stemming from Indigenous health contexts to address social injustice and unequal power relations, but the term is used as applicable to all people receiving care. The erasure of Indigeneity within the concept of cultural safety by nursing can be understood as a manifestation of White supremacy that Dr. Ramsden cautioned against. Neo-liberal and egalitarian discourses expunge cultural safety's original directive to uphold Indigenous rights, sovereignty, and the disruption of colonial violence. In this way, the root underpinning of Indigeneity within cultural safety is subverted by culturalism and indulgence of White fragility. Tang and Browne (2008) affirm that the pervasiveness of egalitarianism discourse within nursing, healthcare, and Canadian society in general insidiously erases the existence of anti-Indigenous racism by asserting that everyone deserves equal access to quality care. This discourse negates the ways in which Indigenous specific racism marginalizes Indigenous Peoples, creating stark inequities in access to care.

4.2 Nursing's Capacity to Affect Change in Disrupting Anti-Indigenous Racism

> …racism will not be fully resolved in our lifetime. But if we cannot commit to these ideals now, and revisit our commitments again and again as we go forward, we will be failing the aspirations of our profession to "improve health globally." (Thorne, 2020, p. 2)

Despite the problematic absence of nursing discourse and action regarding instances of anti-Indigenous racism in healthcare, nursing's contributions to social justice are numerous and,

in the context of addressing racism, nursing has led one of the most important movements to date, cultural safety. As discussed earlier, cultural safety originated from Māori nurses based on their experiences serving Indigenous communities in New Zealand. Cultural safety is an important example of nursing scholarship that informed social and political policy and action within healthcare. The impacts of the adoption of cultural safety on a global scale within healthcare systems cannot be overstated. It have supported individual, organizational, legislative, and systemic change to address anti-Indigenous racism within healthcare. This example of nursing leadership highlights nursing's capacity to lead healthcare policy. Dr. Ramsden, the Indigenous nurse-scholar and influential thought-leader who conceptualized cultural safety, powerfully captured hope for nursing as possessing this kind of leadership for change when she said, "there are three kinds of people: those who make things happen, those who watch things happen and those who never know what hit them--let nurses be in the first category" (Ramsden, 1996). As discussed in Chapter Three, in many ways, nursing within Canada struggles to define, action, espouse, and promote cultural safety intra-professionally. Given that cultural safety is an Indigenous nursing concept and has been championed by nurses globally and within Canada, nursing is primed to build on this momentum and to steward the concept not only for the nursing profession but inter-professionally within healthcare and beyond.

From a social justice standpoint, nursing holds an ethical responsibilitity in decolonizing nursing practice and interrupting harm perpetuated by health sytems and, by extension, nursing (McGibbon et al., 2014). Nursing represents the largest body of the healthcare workforce in the province of BC, in Canada, and globally (Canadian Institute of Health Information, 2021; World Health Organization, 2020). As the largest proportion of healthcare providers in Canada with the most point of care experience, nurses hold tremendous capacity to support healthcare policy and

effect change. When nursing adopts a practice or principle, it has the potential to enact this change through 500,000 nurses nationally. The spirit of nursing leadership is deeply embedded within the landscape of Canadian healthcare and, as such, nurses have an ethical responsibility to use their substantial influence for good. In this way, nursing's role and opportunity for impact in disrupting ongoing anti-Indigenous racism within our current healthcare system is extraordinary.

Within the province of BC there has been considerable uptake of healthcare policy to eradicate anti-Indigenous racism in recent years. At the highest level, BC has recently updated healthcare legislation in the new *Health Professions and Occupations Act* (HPOA) intended for release in 2023 which, for the first time, includes a mandate to: disrupt anti-Indigenous racism, ensure health professionals adopt Indigenous cultural safety within their practice, and implement accountability measures for complaints processes that will protect the public. In addition, the *Declaration on the Rights of Indigenous Peoples* (DRIPA), released in 2019 as discussed in the provincial government/policy mandates section of Table 1, supports the recent updates to the *HPOA* to inform BCCNM's action plan to adopt Indigenous cultural safety within all aspects of nursing practice. As discussed in Chapter Three, while BCCNM should have acted earlier to address anti-Indigenous racism and taken professional responsibility to enact these changes prior to it being mandated through legislative changes or through the findings of the *In-Plain Sight* report, BCNM has been at the forefront of changes in health regulation through its thorough and concerted efforts. BCCM's leadership in the advancement of Indigenous cultural safety is a powerful example of how nursing can and must lead policy and political actions toward anti-racism efforts. In this way, nursing organizations have a collective mandate to influence health and social policy, working collaboratively towards Indigenous cultural safety implementation

throughout all domains of practice by way of nursing regulation, nursing unions, nursing associations, and nursing education.

Nurses deliver healthcare services across a spectrum of settings within five domains of practice: education, administration, research, clinical practice, and policy (CNA). The nursing profession widely acknowledges the importance of nursing's role in the practice domain of policy, and yet, nursing continues to be under-represented in the policy sector and struggles to engage in the politics of healthcare systems (Villeneuve, 2017). While there is clear direction within the nursing profession that nurses have an important leadership role to play in the policy realm, there is a lack of clarity and initiative to support nursing in engaging with healthcare policy, both in individual practice and collectively as a profession. Policy is an important tool for nurses in two ways: first, it guides the objectives, practices, and values of the profession itself; second it supports sound, evidence-informed healthcare through nursing knowledge. In this way, nursing must shed its own internalized oppression and struggle to meaningfully engage and lead healthcare reform, not only for ourselves but, more importantly, to lead social justice and anti-racism efforts within healthcare policy.

Nursing has the moral and professional obligation to use the privilege and power that it does have to address the ongoing assimilation and oppression of Indigenous Peoples. Lilla Watson (1985), a Murri activist, captured my intention for nursing's call to action to address anti-Indigenous racism when she said, "If you are here to help me, you are wasting your time. But if you have come because your liberation is bound up in mine, then let us work together". Nursing cannot fully uphold the ontological ideals of nursing without recognizing that the integrity of its character is tied to the equity, justice, and wellness for all. In this way, nursing must unpack the ways in which it is both benefiting from systemic racism but also wanting to

dismantle it. Leaning into hard truths and engaging in reflexivity as a collective is imperative in actioning anti-racism. The discomfort that comes from the ontological disruption of our collective professional identity cannot come before our obligation to act against the ongoing oppression of a people. The purpose of this thesis is not a calling out but a calling in. It is a recognition of nursing's substantial strength. As a collective, nursing has the capacity for great change. We have done it before, and we can do it again. However, we cannot make these particular changes unless we look within. These truths are hard. Understanding and accepting nursing's complicity in upholding systems of harm is hard. Emancipating from the status quo is hard. In this way, the wisdom and guidance from Elder Gerry Oleman is our call to action: "We cannot say goodbye to a problem until we first say hello" (Oleman, Indigenous Knowledge, personal communications, n.d.).

Chapter 5: Conclusion

In reflecting on the personal and professional growth I have gained from the knowledge that has come through not only the findings of this research but through the process of conducting this research, I believe that the Elder teachings that informed the Indigenous Ways of Knowing in relation to this thesis outlined in Chapter 2 remain the most salient teachings of this work. Elder Evelyn teaches us that the power of nursing care has incredible strength to heal the healthcare system, and that we are all in this work together. As an Indigenous nurse matriarch that has stewarded cultural safety work for over four decades, she shares with us that while this work requires immediate attention based on the urgency of ongoing harm, we must remember that this work will span generations and that our commitment to this work must endure.

Elder Gwen teaches us to stand up for what is right and just, and to always go back to our ethical and professional nursing standards. She reminds us to stay grounded in the teachings of our ancestors, which have guided sound practices and healing since time immemorial. Elder Gwen urges us to stay grounded in the teachings of the Elders, to stay connected to Land and to hold each other accountable as an act of love and respect. Elder Gwen embodies the highest integrity in her courageous ability to speak truth to power as a nurse, woman, and matriarch. Her way of being is a model for us all.

Elder Gerry shares with us the profound yet simple insight that nursing care heals and that racism is in desperate need of healing. Ahenakew (2016) articulates this healing with a similar sentiment, conceptualizing the impacts of colonization as our collective soul wound that requires the healing of the colonized and the colonizer because the pain that is caused by this same soul wound impacts us all and, therefore, our healing and well-being are inextricably linked in our entangled relationality. Elder Gerry reminds us to use our nursing knowledge and practice

to heal the world of racism in a call to action to the nursing profession to take up this important work. Elder Gerry teaches us to always look at hard truths and, for this reason, nursing must acknowledge its own complicity in colonial harm and must reconcile and heal its legacy of racism and colonization.

In closing, I reaffirm my sincere belief that nursing can take up this call to action and that the impact of this work can and will be immeasurable. As a nurse, I continue to dedicate my nursing practice to the mission of the work to address anti-Indigenous racism within healthcare systems through the teachings and findings of this research and lovingly implore all nurses to join me on this journey.

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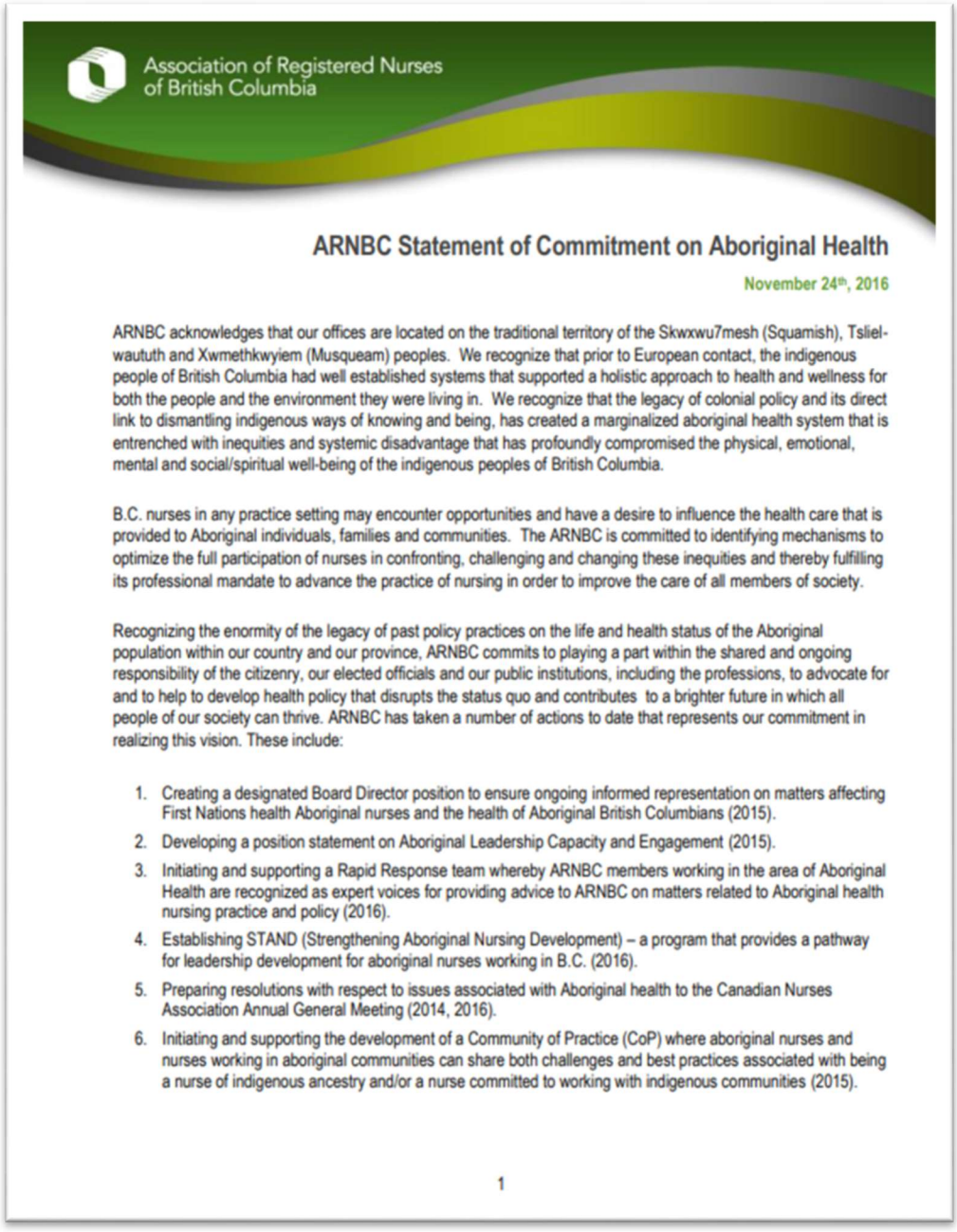
Appendices

Appendix A ARNBC Statement of Commitment on Aboriginal Health



Association of Registered Nurses of British Columbia

ARNBC Statement of Commitment on Aboriginal Health

November 24th, 2016

ARNBC acknowledges that our offices are located on the traditional territory of the Skwxwu7mesh (Squamish), Tsleil-waututh and Xwmethkwyiem (Musqueam) peoples. We recognize that prior to European contact, the indigenous people of British Columbia had well established systems that supported a holistic approach to health and wellness for both the people and the environment they were living in. We recognize that the legacy of colonial policy and its direct link to dismantling indigenous ways of knowing and being, has created a marginalized aboriginal health system that is entrenched with inequities and systemic disadvantage that has profoundly compromised the physical, emotional, mental and social/spiritual well-being of the indigenous peoples of British Columbia.

B.C. nurses in any practice setting may encounter opportunities and have a desire to influence the health care that is provided to Aboriginal individuals, families and communities. The ARNBC is committed to identifying mechanisms to optimize the full participation of nurses in confronting, challenging and changing these inequities and thereby fulfilling its professional mandate to advance the practice of nursing in order to improve the care of all members of society.

Recognizing the enormity of the legacy of past policy practices on the life and health status of the Aboriginal population within our country and our province, ARNBC commits to playing a part within the shared and ongoing responsibility of the citizenry, our elected officials and our public institutions, including the professions, to advocate for and to help to develop health policy that disrupts the status quo and contributes to a brighter future in which all people of our society can thrive. ARNBC has taken a number of actions to date that represents our commitment in realizing this vision. These include:

1. Creating a designated Board Director position to ensure ongoing informed representation on matters affecting First Nations health Aboriginal nurses and the health of Aboriginal British Columbians (2015).
2. Developing a position statement on Aboriginal Leadership Capacity and Engagement (2015).
3. Initiating and supporting a Rapid Response team whereby ARNBC members working in the area of Aboriginal Health are recognized as expert voices for providing advice to ARNBC on matters related to Aboriginal health nursing practice and policy (2016).
4. Establishing STAND (Strengthening Aboriginal Nursing Development) – a program that provides a pathway for leadership development for aboriginal nurses working in B.C. (2016).
5. Preparing resolutions with respect to issues associated with Aboriginal health to the Canadian Nurses Association Annual General Meeting (2014, 2016).
6. Initiating and supporting the development of a Community of Practice (CoP) where aboriginal nurses and nurses working in aboriginal communities can share both challenges and best practices associated with being a nurse of indigenous ancestry and/or a nurse committed to working with indigenous communities (2015).

1

This Statement of Commitment communicates the ARNBC's intent to continue to reflect on, develop, and refine the approaches we take as a profession, including the resources allocated towards acknowledging and addressing our own cultural humility* so that we can effectively contribute to addressing and changing health inequities within our society.

**Cultural humility "is the ability to maintain an interpersonal stance that is other-orientated (or open to the other) in relation to aspects of cultural identity that are most important to the person".*

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