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Historically Informed Nursing in the Time of Reconciliation

Sylvane Filice
Lakehead University, sylvane.filice@lakeheadu.ca

Michelle Spadoni
Lakehead University, mmspadon@lakeadu.ca

Patricia Sevean
Lakehead University, Prof Emeriti, psevean@lakeheadu.ca

Sally Dampier
Confederation College, Sally.Dampier@confederationcollege.ca

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Historically Informed Nursing in the Time of Reconciliation

Cover Page Footnote

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We are all created equal, and only circumstance and history make us what we appear to be on the outside. (Wagamese, 2011, p. 81)

Sioban Nelson (2009) suggests that there are stories that need to be told. Her words echo in our mind, as we sit quietly and listen to students attempting to understand manifestations of racism and discrimination in nursing practice with Indigenous people, immigrants, and refugees. But it's Richard Wagamese's (2011) words that touch our heart: "We are all created equal, and only circumstance and history make us what we appear to be on the outside" (p. 81). "And history" is a thread that needs to be picked up, as it may very well be essential for the challenging conversations we are having with students today. Racism has deep historical roots in Canada. Rethinking history in this time of reconciliation in Canada, particularly in nursing provides a means to reconsider our conversations with students and to reconsider the history of the profession in relation to reconciliation.

The Truth and Reconciliation commissioners understood reconciliation to be establishing and maintaining mutually respectful relationships between Indigenous and Non-Indigenous people in Canada (Truth and Reconciliation Commission of Canada [TRC], 2015). They offer that "educating the heart as well as the mind helps young people to become critical thinkers who are also engaged, compassionate citizens" (TRC, 2015, p. 240). Samantha Crowe from Feathers of Hope (a project sponsored by Ontario's Provincial Advocate for Children and Youth), a First Nation's youth forum that began in northern Ontario and has progressed across Canada, stresses that First Nations and non–First Nations people alike need to understand "our history, and the impacts it still has on everything around us . . . colonization, racism, that residential schools still continue to negatively impact the quality of life in our communities" (p. 240). If we consider her words in the context of nursing and our realities as nurses, it reminds us that as a community, we need to understand nursing's role in the history of residential schools, in the profession's understanding of and subsequent role in the *Indian Act* (Government of Canada, 1985), to understand reconciliation.

We need to engage with students in tension-filled moments, when they are trying to understand the relationship between racism, intergenerational trauma, and the realities of colonial practices in contemporary health care. It can be difficult to understand how intergenerational trauma in today's context is about collective trauma, stemming from historic and current systems of inequities and violence that perpetuate trauma, instead of healing (TRC, 2015). As educators, we are aware that some students in our classroom have personal experiences with intergenerational trauma, and reconciliation may have a more intimate meaning for them. Richard Wagamese (2012) illustrates the different ways reconciliation can be understood. For Richard, a "victim" (his word) of intergenerational trauma, reconciliation is a "big word. . . . Quite simply, it means to create harmony. You create harmony with truth and you build truth out of humility" (p. 133). Subsequently, Wagamese (2011) explains that humility in the Ojibway world is the ability to see oneself as part of something larger. He challenges that without humility there is no unity; it lets us work "together to achieve equality" (p. 10). Humility is a thread we have considered in our work, from our experience and context, when we witness the unspoken pain that crosses the face of students who share with their class that intergenerational trauma is a part of their life. It shapes how they understand racism, safety, and well-being.

In nursing education, Sonya Grypma (2017) makes a striking observation. She argues that the role of nursing history has been unappreciated in the nursing curriculum in the last two decades in the push toward evidence-based and technological health care curricula. Although the majority

of fundamental Canadian undergraduate nursing textbooks include chapters dedicated to exploring the historical development of the profession of nursing, this sort of historical accounting often consumes no more than one classroom hour as content (a superficial grazing). It becomes a recitation of names, dates, and institutions that students memorize for the test and just as quickly forget. While recitations may be useful for tests, they have little value in discussions that open deep wounds.

History as an essential knowledge domain in nursing, with particular conceptualized approaches, that is, historical thinking and corresponding analytical skills, is frequently not overtly attended to in ways that allow practitioners to see the relevance of history to practice and to current nursing issues in the practice setting. Few universities in Canada offer any courses in nursing history (Grypma, 2017; Toman & Thifault, 2012). Grypma (2017) asserted that as nursing faculties focus "on the 'cutting edge,' it has effectively, if inadvertently, severed nursing from its roots" (p. 1). From our experience working with undergraduate and graduate students, nursing students need to see themselves as historical beings and, moreover, see that history has something to say about contemporary practice.

It is important for students to appreciate how their own historical locations shape their understandings and responses to the needs of patients and families whose backgrounds and experiences might be different from theirs. Nurses need to appreciate how their own historical locations are shaped by their understanding of current political, social, economic, and cultural issues in order to engage in difficult conversations, those that open deep wounds. As well, they need to examine how their own belief and value systems, assumptions, and biases, concomitant to the profession's expectations and the institutional and organizational structures, shape their practice, particularly in relation to collective and prolonged trauma associated with colonial practices that perpetuate inequity. These objectives can be reached only, if students are introduced to critical lenses that help them understand how power, privilege, and governing ethical and fiscal forces inform their nursing actions.

What Are Our Intentions?

The purpose of this paper is to explore the need for historically informed nursing in contemporary nursing education in response to reconciliation. Our approach is a reflective one; for readers to understand the relevance of our argument, we begin in our own context with students, in the classroom, discussing racism in our community. The case brings the conversation to ground, providing the *why does it matter?* question and creating the basis of our argument. From a critical social justice perspective, we believe historically informed nursing aligned with social location, intersectionality, and anti-colonial theory is urgently needed in today's practice settings for students to understand how structural inequities and structural violence surface institutionally, their role in them, and theirs impact on the health and well-being of themselves and others. We envision this as an active practice of inquiry, of thinking, questioning, dialogue, reflection, and action.

Contextually Making the Case for Historically Informed Nursing

Recently, in an undergraduate nursing leadership class, students expressed the overt ways in which they were witnessing racism in the practice setting. In the midst of the conversation, students wondered if, more broadly, racism is being normalized somehow in Canadian society. That morning, local news agencies had reported on the death of Barbara Kentner. Barbara was a 34-year-old Indigenous woman who months before had been walking with her sister and was hit

by a trailer hitch thrown from a passing car. She later died from these injuries (Porter, 2017). Barbara's death for some students in the class was a painful expression of the violence they navigate in various ways in their life.

On the same morning, a student referred the class to a comment by then Nishnawbe Aski Nation Deputy Grand Chief Anna Betty Achneepineskum's: "There is an escalation of violence in this city and we must not minimize these horrible situations" (quoted in Porter, 2017). Broadly, students believed racism is a key factor in Indigenous people's health and well-being and wondered what nurses could do to address racism. Others thought that racism is a growing problem in contemporary society. Subsequently, through negotiation as a class, we decided we would dig more deeply: students decided the objective was to figure out what racism means and how racism is situated in relation to the profession and/or nursing practice. We dedicated a portion of our class time over the next few weeks to discussing what we had found through literature and conversations (academic and literary sources, people we thought had wisdom), the arts, Elders, and historical nursing archives (*Canadian Nurse*, online archive). We read writings from legal Indigenous scholar John Borrows and Indigenous scholars Shawn Wilson, Lisa Bourque Bearskin, Janet Smylie, and Richard Wagamese. Simultaneously, we explored the work of critical feminist and anti-colonial writers Annette Browne and Colleen Varcoe, and local Indigenous nurse scholars Mae Katt (intergenerational trauma) and Helen Cromarty (cultural safety). Our goal as a group of learners was to shake up, disturb, and trouble with rethinking our thinking about racism.

One of the big moments for students was reviewing the *Canadian Nurse* journals from the 1950s (online archives) and discovering how the *Indian Act* (Government of Canada, 1985) was articulated by the profession as health surveillance and promotion. Articles like "Eskasoni Indian Reserve" illustrated how the formation of reserves in Nova Scotia at the time was seen by nurses as *centralization* leading to better homes and medical and educational advantages for Indigenous people, particularly children (MacQuinn, 1952), a reflection of the government's rationalization of the *Indian Act.* All of a sudden, John Borrows's *Seven Generations, Seven Teachings: Ending the Indian Act* (2008), specifically his reflection of his family's history going back seven generations since the *Indian Act*, brought the meaning of intergenerational into the open and showed why the terms *racism* and *genocide* come into view when Indigenous scholars discuss the *Indian Act*. The realization by students that the *Indian Act's* function was to diminish Indigenous people's traditional governance and knowledge systems, self-determination, right(s) to land, culture, and language was palpable.

In that moment, history was more than memorizing names, it was a means for students to challenge and trouble with their thinking. They were learning from the writings of nurses in the 1950s that nurses' understanding of Indigenous people was being shaped by governing and societal forces, and they began to question what was shaping their own understanding of racism.

Turning to nursing history, looking at artifacts of a particular time (journal articles), brought them to the realization that racism is more than ideas and is deeply rooted in Canadian society. They decided racism was a set of practices grounded in systems whose function it is to focus on a particular population over generations (the meaning of intergenerational violence) by using well organized controlling practices that privileged one group's economic, social, cultural, legal, and political norms over the other. It marginalizes those seen as less by minimizing their agency, expertise, and value to maintain the status quo of those with inherent privilege and power (the British colonial system). The conversation turned to exploring their own practice and institutional practices that are marginalizing and inequitable to some patient populations.

This is where our interest in historically informed nursing lies, in our practice with our students, colleagues, patients and families, and the sorts of challenges they/we are encountering. We are actively rethinking how we understand history, and whether historically informed nursing aligns with anti-colonial, intersectionality, and social location theory. Might this be a means towards socially just practice in our community, a means to understanding and addressing the issues that matter to the people we care for: racism, classism, poverty, and reconciliation?

Who Are We and Where Are We From?

As women, nurses, educators, and researchers living in a northern and rural area of Ontario coming from Francophone and Métis ancestry, we recognize that we are caught up in the eddy of history, that is, in the legislative, social, cultural, economic, and political change of our time here together. We are vitally aware of how culture, language, and identity can be stripped away from one generation to the next by powerful structures, such as legislation, for example, the *Indian Act* (Government of Canada, 1985), historic legislation that restricts cultural and linguistic rights. Moreover, we are aware of how these structures create barriers in people's everyday lives through assimilation, classism, and social status. Situated as we are, *Honouring the Truth and Reconciling for the Future* (TRC, 2015) final report, *Bill 106* (1990), and an *Act to Amend the French Language Services Act* (Government of Ontario, 2013) have impacted each of us differently in relation to the interwoven natures of our practices, ancestries, and historical locations. The context of our lives as women, nurses, educators, and researchers drew us to Grypma's (2017) argument for historically informed nursing.

In our region, there is increasing concern over the health inequalities reported by Indigenous peoples, sexual and racial minorities, immigrants, and people living with functional limitations, and the haunting impacts of the *Indian Act* (Government of Canada, 1985), the ripple of intergenerational trauma (Public Health Agency of Canada, 2018). However, to understand equality and equity, the report emphasized that critical-contextual perspectives must be taken up by policymakers and practitioners in an effort to visualize the intersecting nature of historical and contemporary colonial policy and practices and the impacts of racism and classism on the health and well-being of Indigenous, Francophone, and immigrant people in Canada (Public Health Agency of Canada, 2018). Furthermore, how such practices replace traditional community strength-based approaches rooted in reciprocity, sharing, and the wisdom of Elders must be considered (Allan & Smylie, 2015).

Wisdom from Contemporary Canadian Nurse Historians

We were drawn to the work of Canadian nurse historians, such as Grypma (2017), Nelson (2009), and Toman and Thifault (2012), recognizing that each has particular perspectives to share that could shed light on the critical intersecting nature of history and the current health care milieu, and how people's experiential stories of accessing care can be honoured. When we viewed their work as a collection, what surfaced, we would challenge, were key curricular questions for nurse educators to assess how and in what ways history is being taken up in the curriculum. Collectively, their works reflect a critical perspective. Their writing spoke to us, as we consider questions that explore how the legacy of colonialism persists in the lives of our students, and for patients and families that seek health care in our hospitals, clinics, and community settings. Their different perspectives make a compelling argument for the reevaluation of history in contemporary curriculum. The Canadian Nurses Association (2007) states, "The practice of nursing takes place within larger cultural, economic and political contexts that have helped shape the discipline. . . .

Therefore, it is important to incorporate nursing history into the curricula of nursing schools and faculties" (p. 2).

Padilha and Nelson (2011) suggest that biographical approaches to nursing history are a means of capturing and exploring personal events and people's locations, motives. and future plans. Toman and Thifault (2012) use historical thinking, which requires particular thinking skills, including how to read primary sources critically, how to examine the evidence, and how to question interpretations of that evidence (p. 187). Grypma's (2017) approach to history premises we are all living history and history shapes our identities. Reading their work, key questions and ideas about the significance of critically examining how nursing history is addressed in nursing curriculum emerge. Grypma (2012, 2017) asks how history informs "nurses' identities." Nelson (2009) pragmatically challenges the questions of why we should bother with the past. Toman and Thifault (2012) argue that studying nursing history provides insights about the evolution of the roles nurses have in today's health care system and how their roles reflect their professional status within the communities they practise in.

How Are We Moving from Reflection to Action?

Thinking about the processes used by Canadian nurse historians drew us to consider how we are attending to historically informed nursing in our own classrooms. Our approaches reflect the context of our rural and remote people, realities, and localities. We consciously think about the impacts of residential schools and the scoop generation, as many of our students live with this legacy, and how they might consider history in their own lives. We think about the importance of language and culture, as Grypma (2017) suggests in her conversation of "identity formation," when Francophone nurses as nursing students recall their experiences of being told not to speak French in the classroom and how they have dealt with these experiences in their own lives (Filice et al., 2019). However, how we teach and construct curriculum is through a relational lens. Relational inquiry honours the knowledge gained through life experiences in relation to human formation and how nursing knowledge is used to meet human ends and created in nursing in response to human needs (Hartrick Doane & Varcoe, 2015).

Relational Inquiry

The curriculum we teach in is rooted in relational inquiry, as articulated by Hartrick Doane and Varcoe (2005, 2015). Relational inquiry was chosen because it pays attention to history, politics, culture, and society. Relational inquiry consists of two interwoven elements: relational consciousness and inquiry (Hartrick Doane & Varcoe, 2005, 2015). Relational consciousness is founded on the belief that people are relational beings and are situated and formed socially (family, friends, significant others, and community) and culturally (culture is lived between people) and by political and historical processes (Hartrick Doane & Varcoe, 2005, 2015). Relational consciousness thus draws our attention beyond the self (individual level) to the relational interplay of the self, others, environment, and context (sociohistorical, cultural, linguistic, economic, political, and ethical/legal forces that shape everyday life). Inquiry is active, it is about questioning, thinking, searching, critically analyzing, and observing (Hartrick Doane & Varcoe, 2005, 2015). The philosophical lenses that support relational inquiry align with historically informed nurses, specifically, hermeneutics/phenomenology (people's lived experiences), critical feminism (the gendered contexts of our lives), anti-colonial theory (which draws our attention to the social conditions created by colonialism), and post structuralism (which pays attention to how language is used).

The Question of Re-envisioning History and Nursing Education

While working together on a historical research project, experienced nurses told us that they had never really thought about their role in nursing history and, subsequently, the importance of capturing and preserving their experiences (Filice et al., 2019).

Sylvane stated:

> I was particularly moved by the stories of Francophone nurses, who shared with me they felt invisible in the history of nursing in Canada. Reviewing the transcripts of Francophone nurses, the complexity of how language, culture, politics, economics and historical context [intersect] comes vibrantly into view. A simple example is how Francophone nurses spoke about being bilingual in a predominately Anglophone health care system. Most reflected that many of their medical colleagues were not French speaking, although they were practicing in rural Francophone communities. The nurses, some of whom were from primarily Francophone families (many transplants, as they noted from Quebec), quickly realized that they would have to be the ones to learn English in order to practice in an English health care system servicing a Francophone community. Subsequently, from a competence perspective, being bilingual had a deeper meaning: They were translators, facilitators, navigators, teachers (for patients/families and health care colleagues) and advocates at the patient and community level. They were the conduit between Francophone and Anglophone society.

In transcripts and field notes, the nuances of politics in everyday health care environments surfaced. For example, Francophone nurses at times were not easily able to identify Francophone nurses in nursing leadership roles at the provincial and national levels (professional nursing organizations), which meant that they had to be creative as to how they brought out concerns related to the health and well-being of Francophone patients/families and communities.

Michelle commented:

> When transcribing interviews, it made me think of my experience as a Métis nurse, and how particular aspects of nursing history have been written about (or not), and in whose voice. The experience of Indigenous nurses from a nursing history perspective, in general, is caught up and written about oft times by non-Indigenous nurses reflecting on nursing Aboriginal people. More recently, however, nurse researchers, for example, Dr. Lisa Bourque Bearskin, are changing this reality, and through her research, we glimpse a deeply contextual view of the history of Indigenous nurses and Indigenous people. Moreover, Bourque Bearskin et al. (2016) and Mary Jane Logan McCallum (2014) are bringing to the fore in nursing Indigenous research methodologies and history.

Nelson's (2009) claim that *memory is necessary* reverberates in our research and teaching practice; historical informed nursing is a means to enacting critical social justice. As Nelson (2009) acknowledges, "We need to know who we are if we have any hope of knowing where we are going" (p. 787). Our experiences have led us to believe that the domain of history at the undergraduate to doctoral levels in nursing needs to be understood and approached through diverse knowledge perspectives (i.e., Indigenous research methodologies, cultural-linguistic lens, intersectionality and social location, and anti-colonial theory) in order to embrace completely what it means to "learn from the blunder of those who came before us and show some wisdom" (Nelson, 2009, p. 787).

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Our Perspective on Historical Thinking…

Given our own interest in exploring the life histories of Francophone nurses, culture is an essential element of our analysis. We approach analysis through an anti-colonial lens, where culture is understood as "a complex network of meanings enmeshed within historical, social, economic and political processes" (Anderson & Reimer Kirkham, 1999, p. 45, as cited in Smye & Browne, 2002). Thus, we resist defining culture as shared values, beliefs, and practices, a narrow lens referred to as culturalism (Browne et al., 2009). Cultural safety stems from the work of Maori nurses in New Zealand who were concerned with unearthing the power imbalances between Maori and the dominant health care culture, which dismissed the robust and historically rooted Maori illness and health belief systems, privileging Western perspectives (Smye & Browne, 2002). In our research, Francophone nurses speak to the issues of power and privilege; they give voice to caring for Francophone people who struggled to gain access to Francophone services. Using an anti-colonial and intersectional lens as an aspect of our analysis brings to light the strength and resiliency of nurses practising in a predominately Anglophone environment and how they navigated institutional structures to advocate for Francophone patients/families. Historically informed nursing as an ontological way of knowing moves the discussion of history beyond objective knowledge or the knowing about some thing or things to making meaning out of "things," as things have context in our daily life (Grypma, 2017).

It opens the possibility of knowing history from a place of intrapersonal, interpersonal, and contextual knowing, supporting students to "penetrate into inner depths and/or ever-changing aspects of family health and healing" (Hartrick Doane & Varcoe, 2005, p. 6). When history is viewed beyond a detached/observer perspective, beyond the reaches of decontextualized and depersonalized knowledge, it enters the space of the personal and contextual uniqueness of people and what matters to them. Relational in this sense "means connections in many forms" (Hartrick Doane & Varcoe, 2005, p. 7). It is a process of being in relation personally, socially, historically, politically, physically, intellectually, and spiritually, such as when we live in relation to other people, the environment, and cosmos (Hartrick Doane & Varcoe, 2005, 2015).

Historically Informed Nursing Examples from the Classroom

The following two examples are from our teaching experiences, where we have deliberately embedded opportunities for students to explore history either from personal experience (of self in relation to heritage, ancestry, and kinship) or at the community and societal level. The examples are from Year 1 and Year 3 in our undergraduate program.

Our work weaves together Dewey's (1938) and Greene's (1978) experiential learning approaches, Paulo Freire's (1970) problem-posing process (dialogue, reflection, action), and Hartrick Doane and Varcoe's (2015) relational inquiry. It encourages students to sharpen their use of memory and recollection. Freire's (1970) problem-posing process of dialogue, reflection, and action helps them visualize and verbalize important life events, when they had to make decisions or choices that shaped who they were becoming. Alongside is the use of contextualized intrapersonal and interpersonal stories (relational inquiry) that helps students make connections between their life experiences, how they think, their decisions, what is shaping their beliefs, and how institutional policies impact their decisions. We draw where applicable from Toman and Thifault's (2012) historical thinking and Padilha and Nelson's (2011) biographical studies.

Year 1: Aesthetic Ways of Knowing Self

> Aesthetic curriculum experience developed in YR 1 of the Undergraduate Nursing Curriculum (Maskmaking) to support students in exploring identity, that is, who they are and where they are from. It develops in the students an awareness of self and an early introduction to the notion of historical being, namely, that they are a part of history and come from a particular place, time, and people. (Spadoni et al., 2015)

Learner Response

Initially students were apprehensive about making masks and could not see the connection between mask-making and their course content (Introduction to Nursing). Words like "arts and crafts" and "child's play" were bantered about. Typically, content (fundamental nursing concepts: ethics, professional standards, compassion, nursing history) is covered in a classroom with small group activities. But this time we were in a gym, hands on with students in an act of caring for another through the messy business of mask making.

Through the next six weeks, we created spaces for reflection and discussion, students worked in pairs through online journaling (course website), exploring the experience and considering the content covered in class. In the classroom, students shared how the experience expanded their understanding of ethics and made them aware of how patient's stories need to be honoured and protected. They discussed not realizing they were a part of history. We linked the activities between two-first year classes, the mask making and journalling was tied to the theory class, while the sharing circles for presenting their two-minute mask story was tied to their communication class.

Students appreciated that faculty had spent time talking about the use of story (theory class) and the inherent responsibilities required when creating, sharing, and receiving stories (for both the creator and listener), relative to the meaning of therapeutic dialogue (communication class). In theory class, we discussed ideas like privacy and intimacy, and the idea of holding aspects of our personal life close, not living it out on Instagram, Facebook, or Twitter. For a generation used to living out loud through Twitter and Facebook with limited ideas about public/private boundaries, this was a real awakening. In their communication class, they were exploring confidentiality and privacy in relation to social media. They reported that creating their story also created space to reconsider ethics and moral ways of being, and what respect and dignity meant to them, along with the realization that intimacy in their lives is important, that they don't need to live out loud in all aspect of their lives. A student reflected:

> As a group, we were immediately vulnerable to each other's stories, and as a result we deeply connected with each other. . . . Knowing ourselves directly relates to the quality of care that we are able to provide. (Spadoni et al., 2015, p. 275)

Students appreciated how the activity matched the evaluation structures in their courses. There were no marks for the masks. In their theory class, students eventually prepared a short paper based on their experience and what it taught them about themselves and the perceptions of what they believed was at the heart of being a nurse. For the paper, they began with their own stories, pulled core nursing concepts from the content being covered in class, and unpacked the concept by linking it to their experience. In communication class, they learned different ways to think about interviewing.

We still do the mask-making activity, and this year at the fourth-year pinning ceremony, a student related the experience of mask-making to the audience, explain how, in those early

moments of being introduced to the foundations of nursing and therapeutic communication, they learned about the significance of compassion to nursing practice and the importance of listening from the heart to peoples' stories. As well, three of our graduates from the original 2014 class are practising in the community setting with people struggling with substance use and depression. They are using mask-making as a means of exploring trauma and how it manifests in people's lives, noting that their clients thought it was a way for them (people living with addiction and depression) to put a human face to mental health and addiction. Their clients believe art is a means of social activism.

Educator's Reflection

In the theory classroom, the students are learning about the historical roots of the profession of nursing in Canada and core nursing concepts like compassion, and (teaching from a relational perspective), we introduce the students to the idea that they, too, are historical beings. For example, when exploring identity with students, you have to think ahead for moments when learners may (or not) discover something within themselves or others that is emotionally triggering; thus, mapping out supports within the educational unit and within the larger academic setting is essential. Working from a relational perspective, learners are introduced to ideas of respect and honouring, which requires teachers and students working together to create shared values and norms related to being respectful of the self and others, considering the how, what, and why of sustaining respectful learning spaces.

Today, most students have grown up in the Instagram, Twitter. and Facebook era, and they speak of the graying of personal boundaries; they struggle with what to share and not to share. Academic writing is a challenge for many, having good relations with the writing centre is important. Not all students are at the same developmental stage in their learning curve, and some require more support than others. We use a variety of student resources from the office of Student Accessibility Services (counselling) and the Student Health Office if needed, to name a few.

Year 3: History through a Windshield and Walkabout Survey

> Community and Population Health Nursing YR 3 of the Undergraduate Nursing Curriculum. Students explore past practices of reaching people in the community and compare to present practices. Examples include the Red Cross train that used to travel to many Northwestern Ontario isolated communities and the present breast cancer screening van (that reaches isolated northern areas of the province). Subsequently, it highlights the role of the community/public health nurse in outreach activities and health promotion; it brings to the surface the challenges faced by people and practitioners in rural and remote areas; hence, it also brings to light how innovative and adaptive northern communities have had to be. One of the culminating activities in the course is a Windshield and Walkabout Survey for assessing community strengths, where students are asked to research historical components of the community's evolution in relation to the context of the development of the community and the community's current needs and challenges. (Filice & Dampier, 2018)

Learner Response

Public health nurses use tools that support on-the-ground community assessment. Windshield surveys are a traditional tool in public health community assessments. But, I (Sylvane) have found as a public health nurse and an educator, the addition of walkabouts creates both a

visceral and a contextual experience of the community: you hear, see, feel, and sense the environment. Students provided insights into what it means to discover practice environments contextually, particularly in their own communities. From an Indigenous perspective, it is a very organic way of exploring the place you live in, noticing things that you have become accustomed to and no longer see.

Community at Ground Level

Students noted that community (even the one where you live, where you feel at home) is new when you walk it. Students wrote about "exploring the city" from "the ground level" and noticing the nuances of life around them: "I hadn't noticed the area." "Physically walking around the community and observing the various needs with my own eyes" helped to understand "the health of the community I live in."

Seeing Real Life

Furthermore, student responses broaden the meaning of the term *seeing*. For students, the walkabouts created spaces for seeing "real life," and in response they wanted to take a "closer look" and "observe the area… more in-depth" and appreciate "what aspects can be improved." More importantly, students were "more aware of the environmental, historical, ethical, cultural, and other influences" that impact the life of the community.

Educator Response

The content within this course focuses on critical perspectives of the social determinants of health (which means understanding the intersection of history, culture, class, race, economy, and spirituality on people's lives and the health and well-being of a community). Students learn critical perspectives of assessing community in relation to public health program planning and development. The goal is to help students understand how communities' function and what health from a community perspective looks like, and to gain a deeper appreciation of the historical underpinnings in a community's development. The challenge is that students often need to appreciate their own assumptions and biases, beliefs, and values about health, community, and well-being. The risk of othering is a reality. As educators, we have to support students in navigating positionality in the work, which can lead to superficial analysis, sometimes labelling and stigmatizing communities from a class position, from a position of weakness rather than strength. It is not uncommon for nursing students to struggle with how their own identities and their evolving professional identities shift their perspectives. They may not grasp how being nurses puts them in a position of power over the patients/families and communities they are working in.

Historically Informed Nursing—Things to Think about in Curriculum

We believe that nursing faculty in planning curriculum need to consider how, when, and where to integrate experiential learning experiences rooted in history-informed nursing that is relevant to their practice. To make historically informed nursing relevant, we suggest faculty consider contextual factors, such as but not limited to community context, student population, student maturation, and critical theories.

Context and curriculum: We teach in an urban/rural university in northern Ontario, the communities we serve are geographically spread out, and many have populations less than 1000. Most had economies based in mining or the pulp and paper industry, which is disappearing. Poverty is a key social determinant in the north. There is a higher burden of chronic disease

compared to other parts of the province, as well as mental illness and substance use (Northwest Local Health Integration Network, 2015).

Student population and curriculum: Some of our students are the first to go to university in their family. Others are from remote communities and have never lived away from home. Some students are first-generation immigrants, and some are refugees. Some are from larger urban areas of the province or the country. There are students in our classroom who are living the outcomes of intergenerational trauma, having parents who are survivors of residential schools and/or the scoop generation, and they themselves have their own experiences of foster care. When history is approached at the intrapersonal level, hidden tensions and misgivings frequently surface in the classroom. For example, some students think that the trauma created by the residential school system is in the past, and people should move on. They question the purpose of staying on reserve. In discussion of provincial health care priorities and the social determinants of health, students challenge whether or not Canada should take in refugees, worried that the government doesn't have the funding to support people living in rural Ontario, never mind refugees. As educators, we have to be prepared to have these difficult conversations. How do you address hard spots with your students? How do you talk about racism, stigma, discrimination, vulnerability, marginalization, and bias? We approach these by introducing students to critical frameworks like social location (which we discuss below). We also have close relationships with Student Accessibility Services (counselling) and create office time for students to talk through challenging episodes.

Student maturation and curriculum: Depending on the learning experience we are creating for students, and the aims and goals of that experience, we are cognizant of how the experience needs to be designed in relation to student maturation level. We think about what course the learning experience is being designed for, at what year level, and subsequently what supporting theoretical courses the student would require to fully maximize the learning experience and knowledge acquisition. We align the learning experiences with the student maturation, and learner need and outcome. In the community nursing course, where students are doing walkabouts, they have completed supporting courses in therapeutic communication, social determinants of health, nursing ethics and social justice, chronic diseases, and mental health management. They have the cognitive and affective skill domains to move forward and grasp higher theoretical perspectives in relation to community-based nursing practice, and can be introduced to lenses like intersectionality.

Theoretical Perspectives and Curriculum

Given our discussion around the importance of matching learning approaches to student maturation and year levels (prerequisites), we approach theoretical perspectives in the same manner. What follows are brief explanations and examples of critical theories we believe align with historically informed nursing: social location, intersectionality. and anti-colonial theory.

Social location theory is about identity formation and how we define ourselves in particular moments in our lives (Kirk & Okazawa-Rey, 2013). It is a means for students to consider their own uniqueness, growth, change, renewal, and regeneration throughout their lifespan (Kirk & Okazawa-Rey). Social location theory can be applied contextually in relation to student maturation and learning level. For example, we introduce social location to the first-year class through a Power Flower model (often used to explore diversity, specifically power and privilege). But in the context of the first-year foundational nursing class, we augmented the model to help students consider their own historical location in relation to their ancestry. They explore questions like the following:

Where do I come from (describe the place you grew up)? Where does my family come from (ancestry, country of origin)? What language(s) do I speak? Where did I learn the language(s)? From whom? When I am at school, do I speak English, and at home, something different? What languages can I write in? What does ethnicity mean, and how does it apply to me and the important people in my life? To date, what have been important moments in my life? We then have them add to it by considering the question of who they want to be (see the stepped social location questions below). Students discovered that identity is fluid; it can be interrupted (by illness, circumstance, or context) and reconfigured and changed over time.

Students learn how identity formation happens in response to the interplay of personal decisions and choices, life events, community reactions and expectations, societal categorizations, classifications, and socializations. As the course progresses, students can begin to think about the following: *Who am I? Who do I want to be? Who do others think I am and want me to be? Who and what do societal and community institutions, such as schools, religious institutions, the media, and the law, say I am? Where/what/who are my home and community? Which social groups do I want to affiliate with? Who decides the answers to these questions and on what basis?* (Kirk & Okazawa-Rey, 2013).

Intersectionality helps students understand how oppression is created through a network of power relations, domination in economics, and political and ideological functions that create privilege for some and oppression for others (Varcoe et al., 2014). *Anti-colonial theory* draws their attention to history and challenges contemporary colonial systems of oppression by bringing to light normalized oppressive practices that rationalize inequities (Varcoe et al., 2014).

Intersectionality and anti-colonial theory are complementary. When intersectionality and anti-colonial theory are used together, they are effective for understanding how structural inequities (policies and practices in health, social services, and justice function to create an inequitable distribution of the determinants of health) and structural violence (a host of offensives against human dignity, including poverty, food insecurity, housing, racism, and gender inequality) shape nurse-patient care relationships (Varcoe et al., 2014).

Conclusion

In this article, we have offered a glimpse of the complexity that arises when teachers and students experience the eclipse of history and contemporary life and how we are attempting to view curriculum as a living force between learners and teachers. We did not want to leave you thinking that the curriculum is bare of actual historical content (even though the courses we describe are not dedicated courses in nursing history). Working from a relational perspective as nurse educators, we shape our course materials around a virtual library of resources that can be drawn from as issues arise and as the context of teachers' and students' lives emerge. Relational practice requires a constant rethinking of the cultural, historical, and political, and the economic landscape of people and the environment. To this end, we have provided (in "Resources" at the end of this paper) an invitation to share our virtual library. On its shelves, you will find resources specific to our region, along with publications of historians focused on the "Indian hospital system," treaties, the understanding of the funding of First Nation health in Canada, and current reports on poverty and homelessness in Canada. As well, you'll find critical theory (anti-colonial, racism, power and privilege, culture, and critical pedagogy) and key Canadian national reports, inquiries, and Indigenous practitioners' policy papers and frameworks. The list is organized around the Canadian Indigenous Nurses Association (Aboriginal Nurses Association of Canada, Canadian

Association of Schools of Nursing, & Canadian Nurses Association, 2009) Cultural Safety Framework recommendations: (1) connections between historical and current government practice; (2) the impact of ongoing colonialism, (3) intergenerational health outcomes, (4) historical trauma, (5) Indigenous strength-based approaches, (6) treaties and land claims, (7) human rights, and (8) the honouring of Indigenous health professionals', researchers', and writers' or artists' contributions.

Throughout this paper, we tethered our conversations to life around us. Like many universities across the country, faculties are responding to the TRC's (2015) Calls to Action. In the classroom, students cautiously approach difficult conversations around racism and discrimination directed towards Indigenous people, immigrants, and refugees. As educators, we need to be prepared to stay in the thick of it and engage respectfully in difficult conversations. What we have discovered is that events that speak to our very humanity, that make our hearts ache, require approaches that speak to what we do with knowledge. Richard Wagamese (2016), an Indigenous writer, scholar, and activist from northern Ontario, has visited our university several times over the years; his thoughts perhaps best capture our perspective of finding ways for students to unpack what they are experiencing and our need to find ways to support students to stay in the difficult, in the rawness of human life. Richard reflected: "Knowledge is not wisdom, but wisdom is knowledge in action" (p. 130). Recitation of abstracted historical facts, memorized for a test, will not help nurses navigate practices that privilege one group of people over the other or perpetuate racism. Like Grypma (2017), we believe that historically informed nursing is an ontological endeavour; it is a relational practice of inquiry in which we employ epistemological frameworks in our search for meaning. Nursing is a practice profession; even our knowledge work has human ends. Thus, when we engage students in inquiry to unpack lived experience by applying anti-colonial, intersectionality, and social location theory aligned with historically informed nursing practices, we do so as a means to unsettle our thinking. When we think about knowledge and Richard Wagamese's notion that wisdom is knowledge in action, he reminds us that we can comprehend many different concepts, but it does not mean that we are wise. It is only as Richard advises: "when I activate those facts and concepts to find the greatest, grandest version of myself, and then use them to work toward that vision, I begin in the process of wisdom" (Wagamese, 2016, p. 130).

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Historical Nursing Archive Material and Regional Residential School Documents

Canadian Nurse—Houses editions of *Canadian Nurse* from 1905 to 1980. Online Books: https://onlinebooks.library.upenn.edu/webbin/serial?id=cdnnurse

Indian News—Digitized collection of the *Indian News* from 1954 to 1982, produced by the Department of Indian Affairs. (Many of our students have family members featured in articles.) University of Winnipeg WinnSpace: http://winnspace.uwinnipeg.ca/handle/10680/451

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