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Article 4

A Nurse's Journey with Cultural Humility: Acknowledging Personal and Professional Unintentional Indigenous-specific Racism

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A Nurse's Journey with Cultural Humility: Acknowledging Personal and Professional Unintentional Indigenous-specific Racism

Cover Page Footnote

We were privileged to have the opportunity to work with Dr. Sally Thorne in the open review process of this manuscript with QANE. | Nous avons eu l'honneur de collaborer avec la Dre Sally Thorne durant le processus d'examen ouvert de ce manuscrit avec AFI.

I am an unintentional racist, a term that has come to light for me through a process of education, mentorship, and self-reflection. I was born in the 1980s as a descendant of white European colonial settlers and raised in a small farming community on the Canadian prairies surrounded by people of similar backgrounds. Conversations and attitudes about Indigenous Peoples generally centred around racist stereotypes. Demeaning and disrespectful beliefs of Indigenous Peoples were common topics of discussion. Childhood games, racist terms, and jokes that generally made fun of Indians all sought to dehumanize, belittle, and humiliate Indigenous Peoples while insidiously contributing to the construction of my worldview. The exposure I had in my community to Indigenous Peoples and cultures was minimal, all supporting the negative stereotypical narrative created by my white culture. The historical treatment of Indigenous Peoples was either disregarded or minimized as something that happened in the past and met with attitudes of "they need to get over it and move on."

In seeking a career as a registered nurse, I attended First Nations University where I was surprised by how many white people were registered as students and the prevalence of white culture in policies, staff, and curriculum. I then started my career as a registered nurse working in an emergency department frequented by clients who were predominantly from an Indigenous background; again, this experience reinforced the stereotypes. On both personal and professional levels, I have never had a negative interaction or felt that I was in any way contributing to Indigenous-specific systemic racism in health care. Despite this, I have come to understand and acknowledge that the foundational beliefs with which I grew up have undoubtedly resulted in my unintended contributions to this narrative about Indigenous Peoples.

Throughout this discussion, the terms Indigenous and Indian will be used interchangeably with the term Aboriginal within referenced materials to describe not only First Nations, Inuit, and Métis Peoples but more inclusively all people whose ancestors lived in Canada prior to European colonization as this provides a more accurate inclusion and reflection of patients affected by colonization and systemic racism (College of Family Physicians of Canada & Indigenous Physicians Association of Canada [CFPC & IPAC], 2016). Moule (2009) defines unintentional racism as "racism that is usually invisible even and especially to those who perpetrate it" (p. 321). Though I have had Aboriginal awareness education in my career, the ongoing reports of abuse, neglect, and deaths of Indigenous Peoples leave me with a sense of guilt and shame knowing that as a nurse, I am somehow playing a role in maintaining systemic racism. I needed to begin my own self-implicated critique that extended in respectful relationality (Brown et al., 2022; Sasakamoose et al., 2020) through cultural humility (First Nations Health Authority [FNHA], 2022) with Indigenous Peoples.

We cannot deny that racism towards Indigenous Peoples in our health care system exists, be it intentional or unintentional. Deaths such as those of Brian Sinclair, Juliette Tapaquon, and Joyce Echaquan, have gained high-profile media attention and demonstrate three horrific stories that are examples of how real racism is and how it is experienced by Indigenous Peoples in the Canadian health care system. Brian Sinclair, an Indigenous man from Manitoba, died in 2008 at the age of 45 after having been referred to the emergency department by his family physician for treatment of a blocked catheter. He died from a treatable bladder infection after being in the waiting room for 34 hours without having been seen by any medical professionals (Gunn, 2017). Juliette Tapaquan, a 39-year-old Indigenous woman from Saskatchewan, died from cervical cancer in 2014. Juliette was on the palliative care ward when a health care worker saw a message on Juliette's phone that led her to be banned from the ward as the staff felt threatened by her. She died

alone and in pain, being unable to access the proper end-of-life care (Pidlubny, 2017). Joyce Echaquan, a 37-year-old Indigenous woman and mother of seven from the Manawan reserve in Quebec, sought medical attention for severe abdominal pain and passed away in September of 2020. She died shortly after capturing her final moments of being insulted and berated by hospital staff in a Facebook live video (Lowrie & Malone, 2020). Sadly, health care across Canada continues to be plagued with many incidents of the racist treatment of Indigenous Peoples and are met with dismissive or inadequate responses such as in the case of Joyce Eschaquon where provincial government representatives focus on statements claiming that most health care workers aren't racist and avoid acknowledging the presence of systemic racism (Fraser et al., 2021; Government of British Columbia, 2020).

The undeniable truth that Indigenous-specific racism still exists in health care has motivated me to take action towards understanding my contributions to racism in health care. Indigenous-specific racism refers to the unique nature of stereotyping, bias, and prejudice about Indigenous Peoples in Canada, which is rooted in the history of settler colonialism. This ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous Peoples have perpetuated power imbalances, systemic discrimination, and inequitable outcomes stemming from colonial policies and practices (Anti-Racism Think Tank [ARTT], 2019; CFPC & IPAC, 2016; Fraser et al., 2021; Government of British Columbia, 2020).

The purpose of this paper is to share my journey in the hope that it will facilitate and normalize the necessary uncomfortable discussions and self-reflection needed amongst nurses for authentic and transformative accountability. These discussions are crucial in identifying how the nurses in health care are personally and professionally contributing to Indigenous-specific systemic racism and how we can move forward in becoming allies and advocate for systemic change. The process of understanding how my knowledge and beliefs about Indigenous Peoples were developed began with understanding colonization, the historical treatment of and the racist views towards Indigenous Peoples, and the colonial policies that have been implemented as a result. Examining the historical treatment of Indigenous Peoples through a framework of cultural humility and safety helped me to gain clarity on how my lack of knowledge and disconnection from Indigenous communities contributes to systemic racism and poor health outcomes for Indigenous Peoples. This lack of knowledge and relational disconnection fostered unintentional racism within my personal life and professional practice.

What I Needed to Know

Education is a way to acknowledge and critically learn how to repair the inequalities and inequities Indigenous Peoples are currently experiencing in the health care system (Canadian Nurses Association [CNA], 2018). It is necessary to explore and understand the historical beliefs and treatment of Indigenous Peoples from the onset of colonialism and the ongoing harmful impact that continues to exist today. Colonial practices and policies are deeply entrenched to support and perpetuate Canadian societal norms. It is crucial to critically understand the historical context of the Indigenous Peoples in Canada as the trauma experienced directly is compounded by racism and inequities in health care, government, education, and policy systems (Sasakamoose et al., 2017).

The stark contrast between Indigenous and non-Indigenous ways of knowing is important to acknowledge as differences in worldviews and power may impact how Indigenous Peoples access and trust in westernized health care. Europeans have traditionally viewed the world from a

hierarchical or top-down perspective, whereas traditional Indigenous worldviews center around interconnected and holistic relationships (First Nations Health Authority [FNHA], 2021; Lux, 2001; Starblanket, 2020). Prior to European contact, Indigenous Peoples lived in low-density communities across Canada and obtained sustenance through a mixture of fishing, hunting, gathering, and farming depending on culture and region (FNHA, 2021; Lux, 2001). Holistic approaches to health were valued by families and communities through connection to land and physical, spiritual, and ceremonial elements. Traditional healing was done by midwives, herbal healers, and shamans (FNHA, 2021).

My perspective has evolved and my commitment to address Indigenous-specific racism in health care was initiated by attending the First Nations University of Canada where I realized there was a gap in my knowledge about Indigenous Peoples. When I genuinely got to know and care for people from Indigenous backgrounds, the fear and stereotypes with which I grew up filled me with sadness and anger. What I had learned from my white culture was not based on truth or accuracy, and the toxic and disgusting rhetoric I had experienced in my culture kept me at a distance from Indigenous Peoples. I found Indigenous cultures and people to be welcoming, kind, caring, and rich with humor and holistic attitudes. I was driven to understand why those stereotypes and fears existed. I realized that the bits of historical information about Indigenous Peoples I had gathered throughout my life was not enough to understand how we got to a place where systemic racism exists. This motivated me to begin learning about the sociopolitical history between Indigenous Peoples and non-Indigenous people through the a) the *Doctrine of Discovery*, b) the Indian Act, c) introduction of diseases and deterioration of health, d) residential schools, e) Indian hospitals, f) Indigenous-specific racism in health care, and g) interpersonal/organizational/systemic racism in health care. This knowledge has helped bridge the gap from what I have been taught to what I needed to know to begin to address Indigenous-specific racism.

Government of Canada Colonial Policies, Laws, and Acts

Colonialism is the institutionalized political domination of one nation over another. There is overwhelming evidence that colonization has had detrimental effects on Indigenous health and culture and is inextricably intertwined with racism (Allan & Smylie, 2015; Currie et al., 2019). Insidious beliefs perpetuated assumptions about the genetic, cultural, and intellectual inferiority of Indigenous Peoples through colonialism. This led to policies intended to separate and segregate Indigenous Peoples from the dominant regime and allowed them to be used for research and experimentation (Government of British Columbia, 2020).

Doctrine of Discovery, 1493

Columbus arrived in North America in 1492; the following year Pope Alexander VI issued the papal bull (formal papal statement) Inter Caetera resulting in the *Doctrine of Discovery* (Assembly of First Nations [AFN], 2018; Indigenous Corporate Training [ICT] Inc., 2020; McIvor, 2022; Native Voices, n.d.). This *Doctrine* gave justification to the European Christians' presumptions of racial superiority by decreeing that Indigenous Peoples were non-Christians and, therefore, not human. Lands not populated by Christians were considered vacant land (terra nullius) and could be claimed in title, jurisdiction, dominion, and sovereignty by Christian European explorers in the name of discovery. The validation given by the *Doctrine of Discovery* allowed European colonizers to subjugate, exploit, colonize, convert, and dehumanize Indigenous Peoples, ultimately laying the foundation for genocide (AFN, 2018; ICT, 2020; McIvor, 2022; Native Voices, n.d.). In 1537, a decree issued by Pope Paul III named *Sublimus Deus* recognized

Indigenous Peoples as "true men," opposed slavery, and recognized their right to land (Native Voices, n.d.; Panzer, 2005, 2008). The *Royal Proclamation, 1763* acknowledged Indigenous Peoples' sovereignty and title to the land. The Crown then took the opportunity to purchase their territory (through treaties) prior to settlement and granted land on which to live (reserves) to the Indigenous groups who were violently removed and forced off their lands and relocated to the reserves (Lux, 2001). During this time, it was measures like starvation, relocation to unusable lands, and the killing of buffalo that lead to the persistent reprehensible treatment of Indigenous Peoples by church and government in order to possess the shared lands outlined in the treaties (Lux, 2001).

As colonial expansion across Canada was directed by the *Doctrine of Discovery*; Indigenous rights were extinguished contributing to the rise of the Indian Act, 1876 and all its genocidal laws and policies "including the residential school system, removal of Indigenous Peoples from traditional lands to reserves, criminalization of languages and cultural ceremonies, and the creation, recognition and later denials of Treaty and Indigenous rights" (ICT, 2020, para 9). The belief that colonial religions, governments, laws, civilizations, and cultures were the only valid institutions gave them the capacity to dominate Indigenous Peoples (AFN, 2018). The *Doctrine of Discovery* remains the base for Canadian existence and law, justifies colonial occupation, and gives the Crown sovereignty/title over traditional Indigenous lands and Indigenous Peoples (Miller, 2019). Despite being recently renounced by the United Nations, the *Doctrine of Discovery* has not been renounced by the Catholic Church, nor the Government of Canada (International Union for the Conservation of Nature, 2021).

The Indian Act, 1876

Several challenges between Indigenous Peoples and colonial settlers emerged in the development of Canada as a new nation that was preparing to expand and displace the First Nations Peoples. The Indian Act, 1876 was developed to erase the treaties already in place and manage the "Indian problem" by giving the federal government autonomy over all matters related to "Indians and Indian lands." The goal of the Indian Act was to "civilize the Indians" through mandatory religious and educational systems to integrate them into society (Lux, 2001; Richmond & Cook, 2016). As part of the Indian Act, Indian agents were created to enforce restrictions placed on First Nations Peoples living on reserve as a response to the government's unfounded fear of an armed resistance. These restrictions forbade First Nations Peoples from leaving reserves unless approved by a signed pass from their Indian agent, who also had the ultimate authority to approve business transactions, celebrations, and public gatherings. These restrictions mimicked those of a totalitarian state but could be circumvented if Indigenous Peoples gave up their status and left the reserve (Lux, 2001).

Diseases and Health, Late 1700s–Current

The health of Indigenous Peoples declined with the introduction of colonial settlers. Infectious diseases that were introduced spread rampantly due to a lack of immunity among the Indigenous Peoples and virgin soil epidemics such as influenza, typhus, and smallpox decimated villages and killed up to 80% of the population; in some cases, diseases were spread intentionally, such as via infected blankets (Douglas, 2013, 2022; Schill & Caxaj, 2019). Other diseases such as measles, mumps, rubella, and syphilis also impacted Indigenous health; syphilis and tuberculosis still disproportionately affect the Indigenous population today (Coletta & Traino, 2020).

Gaps in overall health outcomes continue to exist in Canada between Indigenous Peoples and non-Indigenous people (Government of Canada, 2018). According to the Government of Canada (2018), the life expectancy for Indigenous Peoples is up to 15 years shorter, infant mortality rates are two to three times higher, diabetes rates are almost four times higher for First Nations on reserve, opioid-related deaths are up to three times higher for First Nations in British Columbia and Alberta, and tuberculosis rates are 260 times higher for Inuit.

Residential Schools, 1831–1996

Residential schools operated from 1831 to 1996 and were one of the more notorious ways of assimilating Indigenous children to the Euro-Canadian and Christian ways of living (Hanson et al., 2020; National Centre for Truth and Reconciliation, n.d.). The schools were run by various churches as this model of education was less expensive and solved the problem of finding qualified teachers, resulting in inappropriate and lower education standards that concentrated on prayer, domestic work, and manual labor (Hanson et al., 2020). Children were forcibly separated from their families, forbidden to speak their native language or acknowledge their culture, and were severely punished by staff if they did so. These underfunded schools provided poor nutrition and poor living conditions, facilitating the rapid transmission of diseases. Sick children were kept in the schools, which then spread diseases to other children who were only sent home if they were not expected to live (FNHA, 2021). However, we also know that many children were not sent home when they were sick, as shown by the thousands of unmarked graves that have been discovered at former residential school sites across Canada since May 2021. The Truth and Reconciliation Commission (TRC) was able to confirm that the "government and school officials did not record the deaths for 49% of the children who died in residential schools... nor did they record the names of almost one third (32%) of the students who died" (Thorne, 2022, para 6). The horrendous psychological, emotional, physical, and sexual abuse described by former residential school students not only affects the Survivors but remains embedded through intergenerational transmission (Hanson et al., 2020; Sasakamoose, 2017).

The Canadian government has acknowledged its failed assimilation policy and established the Indian Residential Schools Resolution Canada in 2001 (Indian Residential School History and Dialogue Centre, n.d.). As a result, there were two types of payments made to the residential school survivors, the first was the Indian Residential Schools Settlement Agreement (IRSSA) and the second was the Common Experience Payments (Indigenous and Northern Affairs Canada, 2015). Bobby Cameron, the Chief of the Saskatchewan's Federation of Sovereign Indian Nations declares that the discovery of the children's remains at the Tk'emlups te Secwepemc First Nation makes it clear that "the 2006 settlement agreement didn't encompass or address the true horrors endured by the survivors of Canada's residential school system" (Smellie, 2021, para. 6). Prime Minister Stephen Harper issued an apology in 2008 on behalf of the Canadian government for its role in the Indian residential school system acknowledging the damages done (Government of Canada, 2008), and a year later, at a G7 summit, stated there was no colonization of people in Canada. An apology by Prime Minister Justin Trudeau was issued in 2017 acknowledging the exclusion of Newfoundland and Labrador from the original apology made by Prime Minister Stephen Harper in 2008 (Government of Canada, 2017). The recent discoveries of unmarked graves found at the Marieval and Kamloops residential schools in Canada, as stated and acknowledged by Prime Minister Justin Trudeau, "are a shameful reminder of the systemic racism, discrimination, and injustice that Indigenous Peoples have faced and continue to face - in this country" (Macdonald, 2021, para. 9).

To redress the legacy of residential schools, the Truth and Reconciliation Commission (TRC) of Canada released 94 Calls to Action in 2015, which called upon groups, governments, educational, and religious institutions to amend and advance reconciliation (Government of Canada, 2021). Calls to Action #18–24 speak directly to what can be done in the health care system to educate staff. Call #23 iii includes providing cultural competency training for all health care workers and call #24 includes providing direct classes to medical and nursing school students about Aboriginal health and history (TRC: Government of Canada, 2015).

Indian Hospitals, 1920s–1980s

The segregation of Indigenous Peoples in community hospitals in either basements or "Indian annexes" was the normal practice until after the Second World War when tuberculosis outbreaks became more prevalent and concern rose that "Indian Tuberculosis" would spread to the European population (Government of British Columbia, 2020; Moffatt et al., 2013). The early hospitals grew from the makeshift sanatoriums connected to the residential schools. As the demand for Indian hospitals increased, redundant military barracks were carelessly and inadequately renovated into hospitals that lacked many of the basic features expected in hospitals of that era. Their method of operation was consistent with the colonial system of residential schools and reserves—restricting and segregating Indigenous Peoples from the general population (University of British Columbia [UBC], n.d.). These hospitals were not only inadequate, but they were also underfunded, chronically overcrowded, understaffed with undertrained and sometimes unlicensed practitioners (ICT, 2017; UBC, n.d.), and "rife with coercion and medical experimentation" (Lux, 2016, p. 14). This Eurocentric system excluded and denied traditional cultural and healing practices and forced children, without explanation, into hospitals where they were neglected and abused for years (Government of British Columbia, 2020; Moffatt et al., 2013). The mandated hospitalization for treatment of diseases among Indigenous populations also allowed for experiments for the treatment of tuberculosis to be conducted on Indigenous Peoples. Survivors speak of having surgery under local anesthetic to have pieces of their lungs removed, including sections of their ribs, and bacille Calmette-Guerin (BCG) vaccine experimentation (ICT, 2017). A class-action lawsuit was filed against the government on January 25, 2018, by former patients of Indian hospitals seeking financial compensation and formal acknowledgment of their negligence in operating them (Lux, 2018).

Indigenous-Specific Racism in Health Care

The definition of racism has a broad scope and in its most generalized form is described as the belief that the qualities, characteristics, and abilities of different races make them inferior or superior to one another. This form of discrimination can be experienced on different levels of severity ranging from being poorly treated to intentional acts of violence (CFPC & IPAC, 2016; Lexico, n.d.). A modern definition by Dismantling Racism Works [dRworks] in 2021 describes racism as "different from racial prejudice, hatred, or discrimination" (Alberta Civil Liberties Research Centre, 2021, para 1). Racism, as further explained by dRworks, "involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices" (Alberta Civil Liberties Research Centre, 2021, para 1).

Nursing is an overwhelmingly white profession (Oudshoorn, 2020), and people with similar cultural backgrounds and experiences as mine are predominately the ones delivering health care with Indigenous Peoples in Canada. Indigenous health professionals make up only 1.2% of

all Canadian health professionals and Indigenous registered nurses only make up 3% of the profession (University of Saskatchewan, 2016). These nurses receive their education from a formal curriculum but embedded within it is a pervasive hidden curriculum that influences students' learning environments by sending messages that further marginalize by reinforcing westernized cultural subtexts (Özdemir, 2018; Raso et al., 2019). In a scoping study, Raso et al. (2019) identified that the messages transmitted within the hidden (informal) curriculum often do not correspond to those declared in the official curriculum. These unspoken messages contradict the ethics and values of the nursing profession, drawing attention to the inconsistency between the formal and the hidden curriculum (Cook, 1991; Tanner, 1990). When we are being told by a culture that racism exists, we need to listen to that culture's experience with racism and we must listen with open ears, minds, and hearts. The TRC Call to Action #23i, calls upon all levels of government to increase the number of Aboriginal professionals working in the health care field; and #23ii, to ensure the retention of Aboriginal health care providers in Aboriginal communities (TRC: Government of Canada, 2015). A recent report entitled, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B. C. Health Care* (Government of British Columbia, 2020), shares numerous unpalatable narratives that support the reality that Indigenous-specific racism does exist in Canadian health care.

Interpersonal Racism in Health Care

Despite the codes, recommendations, and position statements released by the CNA addressing racism, interpersonal, organizational, systemic racism towards Indigenous Peoples is still present in health care. Interpersonal racism exists when "an Individual holds and expresses negative thoughts, beliefs, or actions about an Indigenous person or people" (ARTT, 2019, p. 8). Health care workers identify ways they have seen interpersonal racism in practice manifest as stereotyping, unworthy treatment, insulting and ridiculing, not believing the patient, micro-aggressions, premature discharges, inappropriate referrals, misdiagnosis or substandard care, and delay in or denial of culturally appropriate care (ARTT, 2019). Experiences of interpersonal racism are told in numerous stories of health care workers making harmful misjudgments about Indigenous Peoples who seek care as intoxicated or drug-seeking resulting in neglect and delayed care of valid medical concerns, such as stroke or cancer; being stereotyped and asked to leave without proper assessment or care; having child protection services or social workers called in; or threatening/coercing forced sterilization (ARTT, 2019).

Organizational Racism in Health Care

Indigenous-specific racism on an organizational level is exhibited in many ways through policies, practices, and workplace culture (ARTT, 2019). Health care workers are identifying organizational racism in their own practice in the form of criminalizing and/or pathologizing (violence alerts, automatic referrals to child protection services); inappropriate referrals (chemical dependency worker assessment even when care sought was for other issues); grooming of staff by peers (telling staff that Indigenous families use the hospital as daycare for children during certain times of the month/year); acceptance or normalization of substandard care (stroke victims being assumed as intoxicated and receiving delayed treatment); culturally inappropriate and harmful policies, practices, and services (inability to accommodate ceremonial rituals due to rules); Indigenous Peoples not meaningfully engaged in policy or decision-making (delaying or avoiding engagement with Indigenous partners due to assumed challenges); and, differential impacts of health care gaps and systems on Indigenous Peoples (discharging Indigenous clients who were

brought in via lengthy ambulance ride without clothes, purse, or wallet to get home on their own) (ARTT, 2019).

Systemic Racism in Health Care

Systemic racism is the result of historical policies created by colonial governments giving disproportionate power and resources to one social group over another, resulting in unfair and unavoidable inequalities between these groups (CFPC & IPAC, 2016). Though often more difficult to recognize and conceptualize, systemic racism tends to guide and support interpersonal and organizational anti-Indigenous racism through broader public practices, policies, and processes. Manifestation of systemic racism is often revealed in a lack of resources and health coverage complexities, through inequities created and perpetuated by other institutions that impact the social determinants of health (when the health care system is impacted by poverty, inadequate housing, food insecurities, etc.), and values, beliefs, and worldviews (such as those created by colonialism) (ARTT, 2019).

Individual, systemic, and organizational racism are experienced by many Indigenous Peoples when seeking health care, which is exacerbated when issues of substance use, poverty, or stigmatized chronic conditions such as HIV are present (Government of British Columbia, 2020; Varcoe et al., 2019). Despite efforts to educate health care workers on cultural humility and safety, racism continues to exist in health care (Varcoe et al., 2019). Through the stories of Survivors of residential schools and reports such as *In Plain Sight* (Government of British Columbia, 2020) that put forth concrete examples explaining why and how individual and systemic racism exists in health care, we can begin to put the pieces of the puzzle together in our nursing practice. Indigenous-specific racism in health care is occurring and Indigenous People are dying as a result (Government of British Columbia, 2020). The publications of findings and recommendations from Indigenous Peoples-led organizations need to be valued and incorporated into our practice as the perspective of those experiencing the racism is required to determine our level of cultural safety and delivery of safe nursing care.

Discussion

Researching and learning about the history of Indigenous Peoples and colonialism has opened my eyes to the horrific treatment of Indigenous Peoples in Canada. It is clear to me that the narrative I was taught is not even close to the lived reality of what continues to happen to Indigenous Peoples and I am left to wonder why I did not know the truth about the horrific treatment of Indigenous Peoples in Canada. Throughout this process, I have been able to discern patterns of dehumanization and segregation of Indigenous Peoples in society and, specifically, in health service delivery throughout history and in present professional practice. Unfortunately, I also see the same patterns of dehumanization and segregation of Indigenous Peoples in my own personal history, and I can see these patterns in society today. Why was I so unaware of this history and how it all contributes to Indigenous-specific systemic racism? Acquisition of knowledge begins with our experiences, observations, and perceptions when interacting and being in the world and, as such, it is based on an individual's inner knowledge developed through perceptual awareness of lived experiences (Schultz & Meleis, 2012). Brown et al. (2022) challenge nurses to deconstruct ways of knowing and make strides that may feel uncomfortable by examining how ideologies and power can cause harm to our patients and families. Brown et al. go on to explain how the ways of knowing are diverse, yet interconnected, and there is no hierarchy as they provide great meaning and knowledge when used together. A fundamental starting point for me was to

understand my personal and collective knowledge about Indigenous Peoples as the other was developed from the perspective of being a descendant of colonial settlers. In my situation, I had very minimal experiences with Indigenous Peoples, and my perceptions were shaped by my white culture and the community where I was raised. I was taught to be fearful of Indigenous Peoples, which prevented me from learning the truth about their culture and colonial experiences. The only knowledge I had of Indigenous Peoples was based on prejudiced, discriminatory, and racist contexts. This context was passed down through the generations without any knowledge of the international laws (*Doctrine of Discovery*) and government policies related to colonization in Canada that created a culture of Indigenous-specific racism. These intergenerational attitudes and beliefs may have been perpetuated by the marginalization of Indigenous Peoples because of the segregated nature of reserves, hospitals, and residential schools as these harmful acts of colonialism have intentionally isolated Indigenous Peoples from settlers. This ongoing segregation likely contributed to the denial of truth regarding the abhorrent treatment of Indigenous Peoples. Colonialism attempts to strip Indigenous Peoples of their identity, lands, freedom, languages, healing practices, and traditional ways of life. These policies have had lasting effects on Indigenous Peoples by causing physical, mental, emotional, and spiritual harms leading to loss of language and culture, lower education attainment, disproportionate health disparities, and disconnection of family structures (Wilk et al., 2017).

I was raised in the dominant white culture, the same "Canadianized" culture that dispossessed, dislocated, and dismantled Indigenous Peoples rights to be recognized as human beings with sovereignty over their lands, language, and laws (de Zayas, 2021; Starblanket, 2018). Until writing this paper, I had not realized that I was complicit in witnessing how the Government of Canada continues to assimilate Indigenous Peoples by forcing them to assimilate to westernized Canadian culture (Thira, 2006). There has never been a time in my life when I have been faced with a challenge due to my race. All my white cultural needs are inherently embedded within the societal system and structure that have been in my favor since European settlers colonized the western world. In my experience as a nurse, I know racism exists, I have seen it, I have laughed at jokes made, and I've turned a blind eye when I felt that someone was being treated unfairly. I have been in situations where I did not feel I had enough courage or knowledge to say or do anything, and I know that I am not alone. There is a fatal problem with Indigenous-specific racism in health care where Indigenous Peoples continue to face racism and discriminatory practice. Racism is complex and it can be hard to identify the exact moment it enters into the provision of health care; however, I know I can feel it and see what it is—and now I speak up and intervene. This is a responsibility for all health care providers.

Current Regulatory Interventions

Nurses in Canada carry a professional responsibility to provide safe, compassionate, competent, and ethical care (CNA, 2017). It is our duty to uphold these principles and responsibilities by addressing the broad aspects of social justice associated with health and well-being and safeguarding human rights, equity, and fairness (CNA, 2017). The CNA (2017) respects the special history and interests of Indigenous Peoples with regard to the TRC's, 2015 Calls to Action, and calls on all levels of government in Canada to acknowledge the current state of Indigenous health and implement health care rights and actions in partnership with Indigenous Peoples to improve health services. Position statements provided by the CNA (2018) make recommendations to guide nurses in cultural competence, safety, and humility in their practice.

Cultural Competence, Safety, and Humility

The importance of the ability and the capacity of the health care professional to provide quality health care to individuals of different cultural backgrounds in a culturally safe, congruent, and effective manner is paramount in the nursing profession (CNA, 2018). The CNA (2018) considers cultural competence to be an entry-to-practice competence and defines it as "a set of consistent behaviors, attitudes, and policies that enable a system, agency or individual to work within a cross cultural context or situation" (as quoted in Watt et al., 2016, p. 2). This approach focuses on the health care professionals' understanding of the cultural background of their clients and, ideally, begins with a process of self-reflection (Kirmayer & Jarvis, 2019). Cultural safety is both a process and an outcome whose goal is greater equity. Cultural safety focuses on the root causes of inherent power imbalances and inequities in social relationships held over an individual in health care (Browne et al., 2009; McGough et al., 2022) while promoting integrity, social justice, and respect (McGough et al., 2018). The outcome of cultural safety is based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system resulting in an environment free of racism and discrimination where people can feel safe when receiving health care (FNHA, 2022). Cultural humility is a lifelong commitment of self-evaluation and critical self-reflection in an attempt to redress power imbalances to develop and maintain mutually respectful dynamic partnerships based on mutual trust and institutional accountability (CNA, 2018; Tervalon & Murray-Garcia, 1998).

Within our very own professional directives, nurses are required to advocate for the health of our patients. Nursing has an opportunity to respond to the overwhelming data of health disparities experienced by Indigenous Peoples in Canada by advocating and ensuring that they receive safe, competent, compassionate, and ethical care when they access health care. This can be done through various levels of nursing from seeking to provide culturally safe care, modeling cultural humility to our colleagues, and leading a workplace culture that is culturally safe (Thorne, 2022). As nurses and students, we need to address and interrogate the hidden curriculum in nursing education and draw attention to the inconsistency between the formal and hidden curriculum as these unspoken messages contradict the ethics and values of the nursing profession (Cook, 1991; Raso, 2019). Most importantly, we need to support and strengthen a "speak-up culture" to address Indigenous-specific racism in nursing education and the workplace (Government of British Columbia, 2020). Using the principles of cultural safety and humility has allowed me to critically reflect and explore my own uncomfortable and undiscovered attitudes toward Indigenous Peoples, and to understand that I have been contributing to Indigenous-specific systemic racism.

What Can We Do?

For most of my career, I have felt that changing systemic racism was not something for which I was responsible, nor equipped to address. I did not understand what systemic racism was or how it exists and considered it to be a problem that was created by other people and, therefore, needed to be fixed by other people. Throughout this journey, I have come to realize that every single person in health care, regardless of their role, plays a part in addressing and changing systemic racism. We must acknowledge and reconcile our own past and current contributions as a profession in perpetuating Indigenous-specific racism. The profession of nursing is not there yet; if we were, the ethical standards and cultural competencies required in our profession would mitigate and ideally prevent Indigenous-specific racism in health care. We should not stand for anything less than providing dignified, respectful, culturally safe, and empowering care to everyone regardless of race, religion, culture, sexual orientation, etc. (Thorne, 2020).

Healing Centred Engagement, Trauma-Informed Care, and Allyship

All Canadians require healing, including those who have been the oppressor and those who have been oppressed. Healing Centred Engagement is an approach that addresses both the individual needs as well as advocating for the required systemic change to promote individual and collective wellness. Trauma-informed care is one arm of healing centred engagement (Ginwright, 2018). As health care providers, we are seeing and treating the outcomes of the intergenerational trauma suffered by Indigenous Peoples at the hand of colonialism. As nurses, many of us do not recognize the historical depth of this suffering and we tend to look at and treat the symptoms but not the cause (Ginwright, 2018) illustrating our need to reflect on cultural humility and unchecked white privilege (Schroeder & D'Angelo, 2010). Healing-centred engagement expands on trauma-informed care by focusing on healing from traumatic experiences and environments; trauma and healing are understood beyond an individually isolated experience by refocusing collectively on spirituality, culture, and civic action (Ginwright, 2018).

Nurses, being in such a large and influential group, are well poised to take the lead in a movement of allyship within and outside of our profession by partnering with Indigenous Peoples to facilitate effective change. Allyship is "when a person of privilege works in solidarity and partnership with a marginalized group of people to help take down the systems that challenge that group's basic rights, equal access, and ability to thrive in our society" (Nfonoyim-Hara, as cited in Dickenson, 2021, para. 2). According to the CNA (2021), the number of regulated nurses practicing across Canada in 2019 was 439,975, so what is preventing us from taking the lead in this? What more do we need? Government and institutional responses to historical traumas and health disparities have generally been reactionary but perhaps, as nurses, we can be creative and examine ways to effect change proactively. As health care providers, we must constantly continue to improve our awareness and understanding of Indigenous health, and then we need to move from awareness to action. We must take steps to do better, to move beyond giving lip service and start the actual hard work for real change and commitment to authentic allyship (Thorne, 2022).

Answering the TRC's Calls to Action (Government of Canada, 2015) as a profession and engaging in allyship will improve the nursing profession. These 94 Calls to Action were made to advance Canadian reconciliation. If these Calls to Action were implemented by nurses, we may create meaningful change for health equity with Indigenous Peoples; this is a necessary step in redressing the sociopolitical history between Indigenous Peoples and non-Indigenous people in Canada.

Conclusion

I share my story with the hope that it will help nurses feel safe enough to begin examining how their own worldview was constructed and how it is contributing to Indigenous-specific racism. We are not alone in this often uneasy yet necessary anti-racist journey we must face in order to have integrity within our nursing ethics. I understand what an uncomfortable place this is, and that it is easier to deny being racist than acknowledge our role in perpetuating systemic racism. If we are unable to acknowledge that there is a problem with racism in health care on individual, organizational, and systemic levels, we will never be able to change it. The hypocritical nature of denying being a racist on a personal level yet being part of the nursing culture responsible for Indigenous-specific racism is perplexing. Since nurses are mainly dominated by westernized thinking and white culture in health care, we need to begin our own personal understanding of this

colonial history and start to have open, consistent, and meaningful discussions with our families, colleagues, and supervisors.

I encourage you to reflect on your own worldview in a real and vulnerable way, acknowledge the words spoken and experiences you may have had even before you began your career as a nurse. Recognize how hurtful and harmful they are to both you and the people they are geared towards. I encourage you to reflect on if those beliefs still influence your worldview today and if they influence your practice, even in subtle ways. Nurses may begin to recognize their own contributions to Indigenous-specific racism through the same epistemology we use to understand our practice. Through a process of education, accountability, mentorship, and self-reflection, we can begin to address racism. Racism is a significant and avoidable barrier for Indigenous Peoples who are seeking health care. A core competency of nursing is to advocate for our patients; we need to support a culture that stands up and speaks out and educates when we see racism (Government of British Columbia, 2020). We have the capacity to identify, step up, and put a stop to racism in health care. Standing by and allowing even the most minor micro-aggression against Indigenous People is contributing to Indigenous-specific racism. I want to be part of a nursing era that makes the changes that will mitigate this past and actively repair the avoidable health disparities between Indigenous and non-Indigenous Peoples in Canada.

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