The mobilization of anti-racism here is like squeezing a square peg through a round hole: A critical qualitative inquiry into anti-racism in settler-colonial Canadian nursing education

by

Blythe Victoria Bell
BN, University of Calgary, 2003

A dissertation submitted in partial fulfillment
of the requirements for the degree of

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SUPERVISORY COMMITTEE

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ABSTRACT

Anti-racism is a relatively new priority for nursing education. The political mandate to act on the calls to action from the Truth and Reconciliation Commission of Canada Report and the legislation of the Declaration of the Rights of Indigenous Peoples Act in British Columbia, have made this so. This dissertation represents a qualitative study of anti-racism in Canadian nursing education from the standpoint of baccalaureate nurse educators. The purpose of the study was to map the landscape of anti-racism in schools of nursing to identify strengths, gaps, and failings so individuals and schools can accountably develop action plans. The research questions were: *How do Canadian nurse educators engage in anti-racism in their work? What are the structural and discursive barriers to urgently addressing racial discrimination or hegemonic race ideology?* And the sub-question: *How do participants understand the influence their identities have on their anti-racism knowledge and practice?* Data were collected via an online questionnaire and online focus groups in 2021, and was analyzed through a contextualist content analysis. Educators engage in anti-racism through the content they teach, and less so through their instructional methods but are held back by myriad structural and pedagogical barriers. Anti-racist pedagogy remains poorly articulated in nursing curricula and by nurse educators, is often relegated to discrete, one-time courses, and can be confused with Indigenization. Job precarity and institutional resistance act as structural barriers to anti-racism. Nurse educators navigate and participate in cultural and institutional Whiteness which limits the reach and authenticity of any anti-racist effort. Twenty-six structural and pedagogical recommendations are offered. This dissertation is presented in journal article format.

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Acknowledgements

I first want to acknowledge that I am an uninvited guest and settler on the traditional, unceded, and still occupied lands of the Lək̓ʷəŋən, Coast Salish people. University of Victoria dissertation rules say that I cannot include any land acknowledgement but the standardized one on my title page, and so I will use this space instead. The land on which I sit while I write these acknowledgements is a short walk from the gorge waterway which was an important food source for the local Xwsepsum people. It was stewarded with care and respect for the abundance it provided, whereas it is now an industrial and recreational waterway that no one but the birds and seals eat out of. Directly beside my shed-office is the newly opened Kwum Kwum Lelum - House of Courage which is permanent and culturally supportive housing for Indigenous people at risk of, or who were experiencing homelessness, run by the Aboriginal Coalition to End Homelessness. My physical occupation of this space to raise and play with my daughter and dogs in safety and in comfort, and to work on my doctoral research which will leverage my privilege even more, required only that I ask and pay my white settler friends who are the home owners. I am still literally displacing the First Peoples of this land, and am a participant in and benefactor of the settler colonialism that has created the conditions that make Kwum Kwum Lelum a dire necessity to provide for the fundamental human needs of dignity, food, community, and home. I aim to be a good neighbour in my direct relationship with the people I literally share land with, and broadly to all Indigenous people and lands of this settler colonial state by finding ways to offer reciprocity, because all of my opportunities have come at their expense.

Secondly, there are many individual people that have supported me over the last five years on this academic journey. I began in a project-based Master's program *knowing* that I didn't want anything to do with research, and cringing when I told people I was in a Leadership

Studies stream. I owe a great ontological debt to the badass critical feminist educators, Dr. Darlene Clover, Dr. Catherine McGregor, Dr. Bruno de Oliveira Jayme and Dr. Willow Allen, for changing how I think and opening up the world of research to me. In particular I want to thank Dr. Catherine McGregor for believing in me and holding open the door for a doctorate when I didn't know that I was capable and didn't foresee I would ever have the chance to return to graduate studies for a PhD as a single mother. I would also like to thank Dr. Esther Sangster-Gormley who agreed to join my committee at the onset and provided encouragement along the way, and Dr. Maureen Ryan for later accepting my request to join my support crew as external committee member.

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I have been supported and challenged and loved by friends and family in and through the development and writing of this work. My two classmates and fellow PhD journeyers, Dr. Eva Silden and Dorothea Harris (Good) who I now count as good friends. My colleagues and friends Leanne Kelly, Christina Chakanyuka, and Michelle van der Wielen who trust me to work with them and who lift up my work. My friend and neighbour Corrie Peters who mapped all my analytic tasks on my wall with me, who listens and shares her knowledge, and who occasionally delivers doughnuts or cake to my shed-office at 9pm while I'm still in here writing. Johanna Hallas and Sonia who loved, fed, and entertained my girl in this last overnight push to completion. My friends and family that raised the roof on my shed, at times while I was on the midway with my daughter, so that I could have a dedicated workspace; Keltie Craig and Paul Bogaert, Doug Williscroft, and Chris Koziey! To Colin Bell and Meaghan Gibeaux, my brother and sister-in-love, for giving me the kind of support I couldn't get anywhere else.

Lastly, I would like to thank my parents Diane (McAskile) and Doug Bell, who represent one of the generations of nurses and (medical) doctors that I come from, for their immense generosity of time and love in their care of my daughter and pups while I work, and of finances to keep me here, safe, housed, legally represented and fed. It gives me great satisfaction to represent the nurse and Doctor in and of myself; who knew I would carry the tradition on!

Dedication

To my amazing daughter Anayamara Fawn Riversong Holmes Bell,

who almost understands what kind of Doctor I am soon going to be,

and who will have to explain that to others for the rest of her life,

and who supports me even though she would prefer if I were a veterinarian.

I love you so much and this is, in large part, for you.

And also to all of the single mothers and non-binary parents who

have walked this path with fewer resources than I.

You are my hero.

Chapter One

Introduction

This dissertation represents an interrogation of the application of anti-racism in baccalaureate nursing education in Canada from the perspective of nurse educators. The context for this topic is one complicated by layers of historical, social, and political moves in three specific environments and foregrounded by waves of civil and political tension arising from very public and publicized violence towards people racialized as not white, most commonly people racialized as Black and Indigenous. The three contextual environments are Canada as a colonial state, nursing as a racialized profession, and higher education as an exclusive location for attaining social capital. Canada is a colonial state founded through biological racism and religious superiority applied to the First People of this land and enslaved or indentured Others, and Canada carries on as such through its ongoing and un-reconciled harm. Canada is a white supremacist state, so people here are either racially privileged and centered or harmed and marginalized, in perpetuity, by how they are non-consensually racialized. Biological racism is part of the historical foundation of health care in Canada particularly for Indigenous people but that also extends to everyone racialized as *different*. These histories have been silenced and so most contemporary Canadians have been socialized to believe in and identify with a national benevolence, which relegates signs and symptoms of the ongoing harm as evidence in support of deficit narratives.

The professionalization project of white women in nursing more than a century ago leveraged classism, racism and sexism intentionally to carve out a socially acceptable site for white women to work outside of the home. “Nurses have never been OUTSIDE the system…nurses were in fact an integral part of the inequality, racism, and profit motivations that

are embedded in contemporary health systems." (Smith, 2020, p. 1429). This history is also silenced and so alongside the haze of settler memory (as described by Bruyneel, 2021), is a Nightingale haze, where only the most self-aggrandizing versions of nursing history have been outwardly reproduced.

Lastly, higher education is another historical site of broad racist, sexist, and classist exclusion structurally and in epistemological and ontological development which has clear sequelae for today's students (Canty et al., 2023; Cooke et al., 2022; Iradukunda, 2023). These realities have come to the fore through what hopefully (maybe naively) will be appropriately labelled as an antiracist turn in politics and in academic and health settings. Schools of nursing in Canada have been called out as colluding with a racist and violent status quo in the provision of nursing education by not educating students to be anti-racist nurses that have critical knowledge of how colonialism and neocolonialism have made Indigenous people the most vulnerable people in the country. The racial violence in Canadian health care has been well established in literature and government reports (Browne, 2005; Government of Canada Indigenous Services, 2021; Symenuk et al., 2020 and many more).

Nursing schools thus have a public responsibility to stop graduating people into the workforce who will perpetuate dangerously discriminatory conditions through unexamined implicit biases and sustained social patterns of behaviour. Nursing education is not only a root source of discrimination experienced by patients on the frontlines of healthcare delivery, but it is also the frontline where discrimination is experienced for faculty, staff, and students.

There are many questions to be asked to understand why this is so, and to find a path forward. Among them are questions of foundational nursing values and perceived roles, national educational accreditation standards, curricular goals and content, theoretical and pedagogical

approaches, and educator preparedness and positionality. My personal context as a registered nurse educated in Canada, and a current nurse educator here in British Columbia is what grounds the angle of my inquiry. As such I am interested in exploring how other nurse educators in Canada understand and take up anti-racism in their role as educators.

Focus and scope

The specific aspect my study focuses on is the application of anti-racism through and according to nurse educators since it is these people who are facilitating, teaching, or even subverting the actual education that is shaping each annual batch of new nurses. I wanted to get at what is really going on in schools of nursing beyond the performative school and institutional statements to map our landscape authentically and not ideally. Nurse educators are defined as those who work in schools of nursing that educate pre-licensure nursing students as delineated from clinical nurse educators who are employed by health authorities and who focus on the continuing education of registered and practicing nurses. The Canadian Association of Schools of Nursing (CASN) is the accrediting body for baccalaureate nursing education in Canada. To create consistency in curricular assumptions in this study, participants will only be recruited from CASN accredited nursing education programs, which as of October, 2020, were run through 78 Canadian institutions (Canadian Association of Schools of Nursing, 2020a). Unfortunately, there are no CASN accredited schools of nursing in either Nunavut or the Yukon. The study is bound by direct engagement with educators about anti-racism, with no investigation into their places of work, curricula, or policy. I approach educators as knowers through the design of the study, making space in the data collection methods for their experiences and knowledge to dictate the scope of the research in terms of content and conceptual frameworks of anti-racism.

Relevance

Research about nurse educators is scant even internationally. Since nurse educators are the same people that create nursing scholarship, this points to a lack of (public) reflexivity. Accountability as a professional value is purported to be important to nurses and nursing, but accountability for systematized white supremacy and inadequate racial literacy seems to fall outside of nursing's purview (Louie-Poon et al., 2022). As will be discussed in the literature review section, most nursing literature about racism is located in the United States. The studies I have found that focus on nurse educators or the nursing education location do not regularly address racism or anti-racism directly. Coded language and euphemisms are common in literature and discourse around racism such as 'multiculturalism' and 'issues of diversity, equity & inclusion'. Further, many scholars take a broader approach in their work such as investigating social justice.

Claire Valderama-Wallace (2019; 2019; 2020) conducted a study with nurse educators on the west coast of California who teach theory courses with undergraduate nursing students that aligns well with my research. She interviewed 28 people about their pedagogical approaches to social justice and the social influences on those pedagogies. She collected demographic data including gender, age, and race which she used in her analysis to find patterns of engagement in social justice education. She placed her participants approaches to teaching social justice on a continuum between social justice and the status quo and identifies teaching approaches and features of each end of the continuum. Her findings indicate significant differences in critical engagement in social justice pedagogy along "the color line" (2020, p. 3), indicating the significant of racial identities in this work. Her work certainly acts as a foundation to mine.

The problem that my study addresses then, is two-fold. One, that the delivery of anti-racist nursing education in Canada rests in the hands of a body of educators that are unexamined

in their positionality and pedagogy, the knowledge of which may provide insight as to why nursing education is not producing anti-racist nurses. Two, that local contexts require local knowledge; we do not know the racial or ethnic makeup of Canadian nurse educators, how Canadian nurse educators conceive of and practice anti-racism, nor what they perceive to act as barriers to this work in the Canadian context. As validation of the relevance of this study, I am aware of a very similar study by one of the Indigenous Chairs of the Canadian Institute for Health Research (whom was invited to participate in mine) that was conducted 2022-2023 but has not yet been disseminated (Blanchet Garneau et al., forthcoming). I participated in their first round of data collection, and I imagine that between our two studies we likely share many participants. My hope is that their study will provide substance in any area mine does not.

Objectives and research questions

This critical qualitative inquiry aims to address the apparent lack of effective Canadian anti- racist nursing education and of Canadian anti-racist scholarship about nurse educators through the following research questions:

How do Canadian nurse educators engage in anti-racism in their work? What are the structural and discursive barriers to addressing racial discrimination or hegemonic race ideology?

The sub-question in this study asks:

How do participants understand the influence their identities have on their anti-racism knowledge and practice?

The purpose of asking these research questions is to understand the landscape of anti-racism in Canadian nursing educational contexts in order to address its strengths and failings, and to describe how the standpoints of nurse educators influence their anti-racism in order to

increase the visibility of personal accountability for professional development and the institutional accountability for diverse representation at the faculty level.

Methodology

This dissertation is presented in article format so articulation of the study methodology is spread across the chapters, which forecloses on the need for a discrete methodology chapter. My theoretical framework is only cursorily reviewed in the articles however, so I offer more context here by elaborating on the contributions of postcolonial theory, postmodernism, and a settler-colonial lens.

Critical race theory is foundational to the study of racism in the North American context since it was developed to critique the thin veneer of post-racialism. From the critical legal studies from which critical race theory grew, an example is anti-discriminatory laws that failed to account for any discrimination that could be considered implicit (Freeman, 1978); therefore deflecting accountability for politically and culturally steeped anti-Black racism that is a product of centuries of white supremacist enslavement. What was not considered in the development of critical race theory however was the settler colonial context that both then and now erases Indigenous people, and the colonization of their lands and bodies (Ward, 2018). The application of a settler (post)colonial lens is necessary to account for anything that happens in the Canadian context. Postcolonialism recognizes that we are not living in a post-colonial world, meaning that we are not living *after* but *in* (Gandhi, 1998). The prefix 'post' still however invokes a sense of *after* and so to account for the ongoing colonization of these lands and people, settler-colonialism is a more appropriate term.

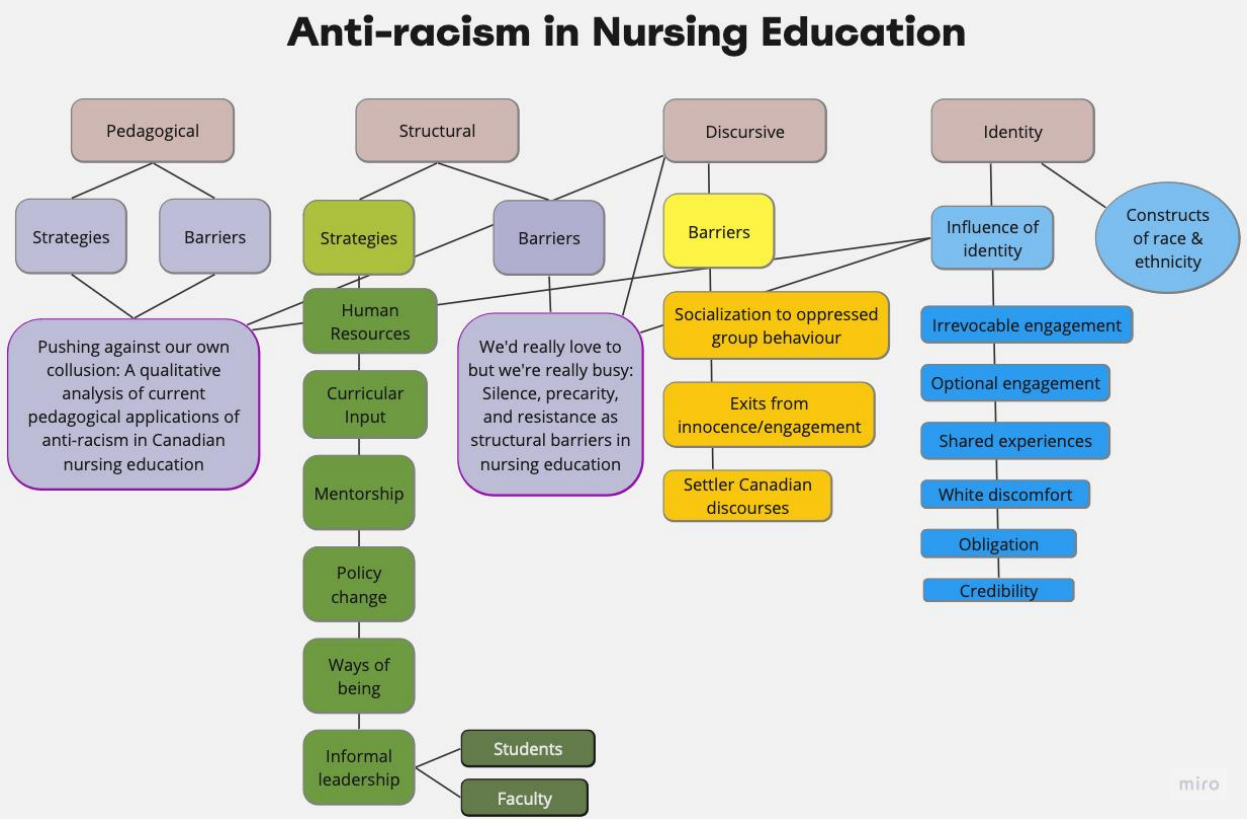
Binarism is an element of postmodern thought that is picked up by many social theories, but the postcolonial analysis of it is particularly salient. Binary oppositions exist to establish

dominance of one arbitrary concept over another, and are thus structurally related to one another (Ashcroft et al., 2000). They are designed to control thinking and the rigidity of the resulting thought denies the possibility of ambiguity or of marginality. The global imperial project designed the constructions of race to support a white:non-white binary which erases the vast continuum of ethnic variation and cultural specificity, including the possibility of North American Indigeneity, and which colonial discourse is founded on (Ashcroft et al., 2000).

The induction of colonial binaries as the frame through which to understand social life in countries colonized by white people, such as Canada, firmly established the *racialized Other*. Nursing practice and nursing literature, as products of people who live in these contexts, has problematically reproduced this binary colonial discourse in its attempts to come to terms with Canada's plurality. Transcultural nursing and approaches such as cultural sensitivity took up the task of learning about, and being tolerant of, the Other without unpacking its self-positioning as dominant and normal. I will also argue in chapter 4 that Indigenization is now being applied similarly. Leela Gandhi (1998) tells us that a deconstruction of colonial relationships requires revisiting and interrogating the colonial past, but learning to proceed through self- understanding in the present. The structural position of power a healthcare worker in Canada has over a person seeking healthcare, or a post-secondary educator over a student, creates a relational dynamic that has proven very challenging to decolonize. Indigenized people and other people racialized by the white:non-white binary continue to experience denigration in nursing environments as if they were unworthy of care and should be grateful for any service provided. As a white Canadian nurse, I am still working to eradicate or at least navigate the social construction of binarism from and in my thought and writing. Even in my identification as a white person, since white and non-white are structural positions white is not what I am, but rather where I exist (Frankenberg,

1993). A resistance to binary constructs in my study design is the collection of identity construct data beyond race, to ethnicity to complicate the binary, and beyond male/female sex to sex and gender, in all their possible forms. This is an effort to explore the social world more authentically and in an anti-colonial frame. Ashcroft, Griffiths and Tiffin (2000) argue that the very domain of postcolonial theory is the space between imperial binaries; its attention on complexity in order to disrupting imperial logic. Gandhi (1998) also explains how colonial relationships are far more complex than the racial binary suggests in that all people in a colonial context are influenced by the colonial discourse; that all people are actors, or as my colleague Leanne Kelly always says, "we are all treaty people".

Figure 1 Landscape of the study



Again, since this is an article-based dissertation, not every aspect of the study data are explicitly represented in the articles about the findings. I offer this map in figure 1 of the entire

study to contextualize the data and analysis components. The elements represented in the included articles (represented in the figure in large purple boxes) respond directly to the research questions. The sub-question about how participants understand the influence of their identity on their knowledge and practice of anti-racism is answered throughout the manuscripts and not in discrete sections. Out of interest one of the structural strategies, Informal Leadership, is briefly captured in a virtual conference presentation that is available online (Bell, 2023).

On representation

A strength of this study is that is drew participants in such a way that whiteness may actually be underrepresented, but without national statistics on racial identity this cannot be confirmed. Demographic tables are included in the manuscript chapters but they don't provide specifics of the participant representation as I was working to maintain absolute anonymity for the participants. A handful of people subverted the question asking for their racial identities by saying they are "human" or that they don't have a racial identity, so I cannot claim to know what they are. Beyond that small number of people (6%), 62% of the participants were white and so around 32% of the participants were not. In terms of representation, having 32% 'racialized' study participants actually surpasses the norm in nursing education, if I rely on data from the United States; these reports set the percentage of white people in nursing education to be closer to 80% (Carson-Newman, 2020). We do not have clear data in Canada about racial identities in the population broadly nor in nursing specifically beyond the data that reports 3% of nurses are Indigenous (Canadian Indigenous Nurses Association, 2018). 4% of my participants are Indigenous, and so where I critique my study in chapter 3 for a "relative absence of Indigenous voice and experience" I am referring to the lack of an Indigenous-specific focus group.

Identity and Reflexivity: The Reformed Smoker

The articles that make up this dissertation each contain sections that position myself structurally, racially, and in the context of this study, so I won't repeat it here. What is left to account for is the evolution of my ego's hold on this research and how this played out in terms of methodology. I initially proposed a critical discourse analysis on my data which I now know was informed by a desire to produce gotcha! scholarship, which would position me as more advanced in my critical awareness than my participants, and might cast me as 'one of the good ones'. I was approaching the engagement with other nurse educators as a reformed smoker might, full of derision for bad behaviour. A benefit of the research process being stretched over several years is that I had time to get humbled before imposing myself on my participants and their lived experiences. I have since become aware of those tendencies in myself, and in white people generally, as an exit from continued self-criticality and a deflection of complicity. "We righteously consider ourselves white people who have evolved beyond our racist conditioning. This is another level of denial. There are no 'exceptional white people'" (Olsson, 1997, p. 4).

What happened during the focus groups and data analysis is that I learned *a lot* from my participants about the realities of full-time and long-term work as a nurse educator and about navigating cultural, discursive, and structural environments when trying to teach anti-racism and be anti-racist. The depth and breadth of experience and perspective shared with me through the questionnaires and focus groups pushed me to reconsider approaching the data with solely critical intent to deconstruct participant and institutional discourse. I felt, and accepted, a responsibility to also represent the knowledge and the challenges of the participants essentially, as valid and believed lived experience. This became especially important to me as I witnessed frustration and exhaustion in participants at not being heard in their work environments, or not

being safe enough to try to be heard. This dissertation not only maps anti-racism in Canadian nursing education, but also represents a map of my anti-racism, as a white Canadian nurse educator. I am within and without of this container of very personal and broadly professional inquiry.

On language

I of course understand that the acronyms BIPOC and BILPOC and POC and IBPOC have been developed by (some of) the people represented by these terms and that they are fairly socially acceptable. Even socially required in some circumstances, as acknowledgement of the self-designation. But I am not one of these people. We know these terms reflect the process of racialization that is a tool for domination and extraction, and not intrinsic qualities of people. I am particularly uncomfortable applying the term People of Colour as a white person who can have no idea how all of the people in the world who aren't racialized as white, Black, or Indigenous feel about being given this label. There is no racial label that I can choose to put on someone who isn't white that isn't potentially problematic and likely harmful. I have been focused on using language that centres the process of racialization as a tool for power and control rather than implicitly reifying racial categories. I have used different language in each chapter of this dissertation, as evidence of evolution of thought, and also of evidence that none of the words I've tried on have done the work of talking about race on people unproblematically. I use *racialized* and *white* in chapter 2. I use intentionally awkward but descriptive acronyms in chapter 3 to represent *racialized as white in the white supremacist binary*, *racialized as Other in the white supremacist binary*, and *white-passing in the white supremacist binary* (RWB, ROB, WPB). Lastly, I use *racialized as white* and *racialized as marginal* in chapter 4. Beyond the

evolution of my own thought being represented by these changes, I am also inviting critique and commentary by publishing with them.

What I have also learned recently is that I have been giving myself permission to use some language that I do understand critically, but which can't be understood by my writing because I don't explicitly say so. Examples are how I used the term 'racialized' in my literature review papers. I had come to know by the time I wrote those papers that everyone is racialized in a system of racial hierarchy. I applied the term 'racialized' to people racialized as something other than white because it is a conventional use of the term and it maintains the focus on racialization. What I hadn't considered though was the impact of continuing to use the term that way without explicitly acknowledging that it continues to center whiteness. So where I didn't acknowledge in my writing that white people are also racialized but get to exist in the cognitive dissonant soup of racelessness, then I participated in the reification of white as raceless. I had to learn this again very recently with my use of the term post-colonial, knowing full well the tension it causes particularly in my Indigenous colleagues and friends, because I assumed it was enough that *I know* we're not post- anything, but still in the present of colonialism, regardless of whether I explained that in my writing. So, this is why I am fumbling around with iterations of awkward language. I'm working to be clear and accountable in a sociopolitical context that is anything but.

Structure of the thesis

Chapter 2: Literature Review

This chapter is comprised of three sections that together review the nursing literature on racism and anti-racism in nursing education. First is a published literature review that makes up two thirds of my literature review completed late 2019, and which is now broadly cited in

nursing scholarship about anti-racism. This manuscript addresses critiques in the literature about the political 'safety' of nursing education, and studies focused on nurse educators. Second is an unpublished paper that covers the ideology of Whiteness and enactments of Whiteness, as the final third of the same literature review. Due to the antiracist turn there has been a marked increase in nursing literature with an explicit focus on racism and anti-racism of late, so last is a brief overview of literature published between 2020 and 2023 as addendum.

2.1 White dominance in nursing education: A target for anti-racist efforts

2.2 Whiteness as a barrier to anti-racism in nursing education

2.3 Literature review addendum

Chapter 3: "We'd really love to but we're really busy": Silence, precarity, and resistance as structural barriers to anti-racism in Canadian nursing education

This article describes structural barriers found in the study data and provides a deconstructive analysis of mechanisms of institutional white silence. Identified in this chapter are overarching processes of precarity and resistance that exert power over the environment and provision of nursing education, and which act to destabilize, disrupt, and discourage anti-racist efforts. The study methodology is well articulated in this manuscript. This manuscript is conditionally accepted for publication with the Journal of Advanced Nursing.

Chapter 4: [anti-racism needs to be] Spread not sprinkled: A qualitative analysis of pedagogical applications of anti-racism in Canadian nursing education

This article reports on the range of pedagogical strategies the research participants engage in, or wish they engaged in, and the complex web of barriers that interfere. Recommendations are made for curricular restructuring of nursing fundamentals, uptake of interdisciplinary

knowledge, and for anti-racism to be applied inclusively. This paper is ready for submission to a journal.

Chapter 5: Conclusion

The conclusion contains a summary of main points made in the findings chapters, broad study contributions, and a reiteration of the 26 recommendations made throughout the writing. I address research validity through the concept of catalytic validity and close with my next steps.

Chapter 2 – Literature Review

2.1 White dominance in nursing education: A target for anti-racist efforts

Permissions

Original citation

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Abstract

Literature on racism, anti-racism, whiteness, nursing education, and nurse educators was reviewed and analyzed for the development of race consciousness and application of anti-racist pedagogy. The literature describes an oppressive educational climate for non-white identifying people, a curriculum that does not attend to the social construction of difference, and a nursing culture that is not consciously situated in a broader sociopolitical context. A particular focus on studies of nurse educators demonstrates a stark need for personal and professional development towards effectively delivering anti-racist pedagogy and a deconstruction of white normativity and dominance amongst white faculty. The protection and reproduction of white privilege is identified through the scholarship itself through a lack of racial analysis, an externalization of the root of oppression, and non-specific study measures and outcomes. The persistence and pervasiveness of white dominance in nursing and the lack of anti-racist competence in white educators, particularly, merits a shift in anti-racist efforts away from short-term skill acquisition initiatives towards the deconstruction of socialized white supremacy and enactments of white privilege in nurse educators themselves.

Keywords: anti-racism; competence; nurse educators; nursing education; racism; whiteness

White Dominance in Nursing Education: A Target for Anti-Racist Efforts

We are in a very important moment of reckoning with the racial climate of institutions in white dominated countries and with the persistence of white supremacy in society despite of over one hundred years of rhetorical progress. The publicized death of George Floyd in the United States by a member of a public institution, amidst the COVID-19 pandemic that has laid bare health inequities along race and class lines, has sparked a global anti-racist uprising. In the peak of demonstrations, often led by the Black Lives Matter social movement, all manners of institutions and organizations were compelled to, and called upon, to state their commitment to racial justice. In this heightened moment of racial awareness is the opportunity for nursing organizations to move beyond the performativity of issuing statements, especially those that sanitize the nursing profession as if it were free from racial injustice. The American Association of Critical Care nurses claims that "as nurses we provide care that respects the inherent dignity of every person, without prejudice" (AACN, 2020) and yet overt examples of racial violence in healthcare and higher education are reaching, and shocking, the public, such as the blood alcohol content game allegedly played by emergency nurses and doctors in Victoria, BC (Schmunk, 2020, see also #blackintheivory on Twitter). In a profession bound in practice by a code of ethics with the claim of having a social justice ethos, reaching an understanding of the true racial climate of nursing can be startling (Markey & Tilki, 2007; Vaughan, 1997; Xu, 2008) despite narratives of discrimination and violence, and scholarship and scientific data supporting claims of differential treatment long-existing in the public domain. It is argued that the caring identity and genuine desire of people who become nurses to be helpful obfuscates the reality that nurses do not operate in their professional role in isolation of their socialization, their socioeconomic and political contexts, nor of their identities as racialized or non-racialized beings (Hassouneh,

2006; McGibbon & Etowa, 2009, Schroeder & DiAngelo, 2010; Van Herk, Smith, & Andrew, 2011). Nursing and nursing education operate within the social and political contexts of institutions of higher education and health care in colonial countries with racial beliefs as organizing principles (Puzan, 2003). Nurses in Anglo-colonized countries are predominantly white people (Abrums, Resnick, & Irving, 2010; Beard, 2016; Cortis & Law, 2005; Hassouneh, 2013; Schroeder & DiAngelo, 2010) and the nursing profession is stratified along racial lines, with white people occupying more of the stable and valued clinical positions, and more leadership positions in all nursing sites (Alleyne, Papadopolous, & Tilki, 1994; Cortis & Law, 2005; Grant-Mackie, 2006; Gustafson, 2007; Scammell & Olumide, 2012; Schroeder & DiAngelo, 2010; Van Herk et al., 2011; Vaughan 1997). This normalized dominance gives white nurses the privilege of identifying with their professional role without necessarily acknowledging their role in a racial hierarchy (Van herk et al., 2011). This is to say that the normalization of a white majority and white leadership makes race ignorance possible. Belonging to a longstanding racial majority enables, but does not dictate, partial awareness of the racial climate.

Data from the United States estimates between 73 and 81% of nurses self-identify as white (Health Resources, 2017; Carson-Newman, 2020), and 81% of nursing faculty self-identify as white (National League, 2020) as compared to 2010 census data that identifies only 60% of US citizens being white-identified (United States Census Bureau, 2020). While monitoring of the ethnic and racial makeup of nurses should be "seen as a positive part of an institution's commitment to equality…" towards achieving justice (Cortis & Law, 2005, p. 208), Canadian health institutions and nursing boards have not systematically collected this data (BCCNP, personal communication, 2020; Canadian Nurses Association, 2009). This trend is mirrored today during the COVID-19 pandemic where at the time of writing this article just three

provinces have begun collecting racial and ethnic morbidity and mortality data six months into the pandemic, despite data from other countries demonstrating significant disparities along these lines (see Gawley, 2020 and Kwak, 2020). “Without an evidence base, the inequitable experiences of marginalized populations are dismissed as anecdotal and interventions are not prioritized” (Obiorah, 2020, np, as cited in Nasser, 2020). Further, the omission of this evidence is demonstrative of Canada’s ideology of colourblindness, which is taken up further below. It bears questioning who has the power to make these decisions of omission as compared to who the data impacts and/or represents, and then considering what impact equitable representation in leadership might have.

This paper is a result of a literature review on racism, anti-racism, whiteness and white privilege in nursing education with a particular focus on nurse educators. The literature proved illuminating through its development over time from questioning the presence of racism to critical analyses of racist ideology and discourse. Articulated in this paper are central critiques found in the literature of the problematic absent politic and discriminatory climate of nursing education. Further, literature that explicitly focuses on nurse educators, of which there is very little, is analyzed for the reproduction and protection of white supremacy and white privilege. This analysis provides an understanding of how research efforts and scholarly discourse can continue to hinder while they attempt to help. It also illuminates a path for more authentic and fundamental change that some scholars have been long calling for; a reorientation of anti-oppressive initiatives towards the source of oppression rather than its symptoms. A third section of the original review includes a deeper analysis of enactments of whiteness and whiteness as ideology and is submitted for publication elsewhere. While every angle of oppression and discrimination in nursing merits scrutiny and transformation, this paper focuses on racism and

the continuing development of anti-racism in the profession. Addressing oppression broadly does not attend to the specifics of racist ideology. Lastly, this paper centres whiteness and my voice, as a white woman, in a moment that is resoundingly asking for the amplification of Black, Indigenous and other marginalized voices. Whiteness is centered in this paper as a location for critical intervention and I hope to reflexively contribute to the development of anti-racism in my profession with my voice.

Literature Search Methodology

Summon 2.0, the research tool of the University of Victoria's library catalogue, was used in order to capture multidisciplinary angles on anti-racism, privilege, and whiteness in higher education. Much of the multidisciplinary literature on whiteness reviewed is represented in the separate manuscript previously mentioned. One Summon 2.0 search was compared to CINAHL using the exact search terms and filters, and content was comparable yet with a much broader scope found in Summon 2.0; for the period of 1990-2019 there were 60 hits in CINAHL as compared to 638 in Summon 2.0. Search terms used in various combinations were: nurse education; nurse educators; nursing faculty; nursing curriculum; racism; anti-racism; anti-racist pedagogy; privilege; whiteness; and professional development. Searches were done in parcels of decades to understand the development of this body of scholarship over time and which demonstrated the bloom of literature about racism and privilege in the last twenty years. A search of all years leading up to the millennium returned 593 hits in Summon 2.0, whereas the following decade alone yielded 1338, and the next, 2010-2019, yielded 1762 hits. As this analysis was not intended as an historical account per se, my focus was on the more recently published literature. I do, however, include several pieces published in the 1990's when they included an explicit lens on racism.

Articles were first selected for obvious connection to the themes of racism, discrimination, critical social theories, and anti-racist pedagogy, and subsequently narrowed down to articles about nursing faculty and whiteness. The ancestry method was used to locate further relevant literature and several sources were included for relevance from the authors' collection. An attempt was made to include a significant number of Canadian studies to ground the review in the most relevant context to my practice as an educator in Canada. From a total of 136 peer-reviewed articles, books and book chapters initially selected for review, 46 were selected for the larger literature analysis project, 41 of which are included in this paper. Throughout the revision of this manuscript for publication further salient articles have been referenced.

Politically 'Safe' Education

Nursing education is heavily criticized in the literature for its complicity in delivering politically soft curricula (Alleyne et al., 1994; Hassouneh, 2006) that do not address racism and other oppressions (Blanchet Garneau, Browne, & Varcoe, 2018; Cortis & Law, 2005; Fahrenwald, Taylor, Kneipp, & Canales, 2007; Hassouneh, 2006; Holland, 2015; Markey & Tilki, 2007; Walter, 2017) and that continue to reproduce dominant norms such as whiteness, heteronormativity, middle and upper-classism, and positivism (Allen, 2006; Duffy, 2001; Hassouneh, 2006; Scammell & Olumide, 2012; Tengelin & Dahlborg-Lyckhage, 2017; Van Herk et al., 2011). Given the aforementioned racial stratification in nursing leadership, theory and framework development in this non-inclusive environment can result in critical perspective absences (Jefferies, Aston, Murphy, 2018). If these leadership positions are occupied by a saliently homogenous group, the lack of perspective that comes with lived experience will shape the outcome regardless of significant individual racial literacy. This is reflected in the values and

experiences that are communicated through a curriculum, and communicated through what is absent in a curriculum (Allen, 2006; Scammell & Olumide, 2012). Representation at all levels of healthcare is necessary in order to provide relevant and safe care and education to marginalized people (Jefferies et al., 2018; Vukic, Jesty, Mathews, & Etowa, 2012; Vukic, Steenbeek, & Muxlow, 2016).

The problematic tenets of a liberal multiculturalism such as colourblindness and equal treatment that arose in the post-civil rights era as indicators of social progress are present in the narratives of today's nursing students. Specifically, they are present in my third-year nursing students of 2019; a group of almost exclusively white women in their early twenties. Colourblindness has people pretend they cannot see the colour of a person's skin and claim that it is inconsequential. The equal treatment ideology lives in nurses' claims that they treat everyone the same; that they treat everyone with equal respect. Both of these expressions and practices serve to erase race, the very real impacts of racism, and discredits other social causes of disparity (McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014; Thorne, 2017). The fact that the age of these students has not precluded them from adopting these forty-year-old ideals speaks to the ubiquitous nature of both personal and professional socialization and the persistence of these race-erasing ideals in nursing. Socialization is seen by many as the primary device of professional identity development and encompasses an interactive process in both educational and practice environments of internalizing values, skills, norms, and culture of the nursing profession (Öhlén & Segesten, 2002). Problematic values, ideals, and culture, unless intentionally interrupted, are reproduced in upcoming professionals through daily exposure to their presence.

The tenaciously predominant culturalist approach to nursing across difference not only misunderstands the dynamic complexity and relationality of culture, it reifies difference in an Othering process; nurses learn about Other people who have something called *culture.* As such it silently reproduces Eurocentric normativity and erases processes of racialization and oppression (Baxter, 1998; Browne, 2005; Browne & Varcoe, 2006; Drevdahl, 2001; Duffy, 2001; Hassouneh, 2006; Holland, 2015; Tengelin & Dahlborg-Lyckhage, 2017; Thorne, 2017; Van Herk et al., 2011). Race and racism are fundamentally underdeveloped in this approach, if not ignored completely. Instead it is assumed that quality care can be provided so long as the nurse acknowledges, understands, and respects a client's culture. Culture, in a culturalist nursing approach (transculturalism, cultural sensitivity, cultural competence) is understood as a static, consensual, and identifiable set of values and practices distinctly tied to ethnicity that nurses need to understand and respect, rather than a living, breathing, constantly changing expression of being that can be very individual, depending on each person's intersecting identities and political and social environments (Baxter, 1998; Browne, 2005, Browne & Varcoe, 2006; Duffy, 2001; Scammell & Olumide, 2012). Culture is socially and politically mediated and affected by all identities of each person. It extends far beyond ethnicity to any facet of identity, as values and resulting relational practices are grounded in the multiplicity of people's experiences.

Coded signifiers for race such as culture, ethnicity, and diversity are used in the literature, often interchangeably, and where race is mentioned it is often conflated with culture which results in nebulous ideas about difference (Browne, 2005; Browne & Varcoe, 2006; Cortis & Law, 2005; Drevdahl, 2001; Scammell & Olumide, 2012). A culturalist perspective fails to acknowledge the social construction of these categories of difference and that they are a product of, and reproduce, relationships of dominance and subordinance (Allen, 2006; Blanchet Garneau

et al., 2018). In some forms, culturalism has neglected to progress beyond liberal post-racialism where it is believed that discussions of race are outdated and unnecessary (Cortis & Law, 2005; Thorne, 2017).

The aim of this literature review was to identify literature that directly addresses racism, as it is my position that explicit and sustained dialogue about the systemic and personal maintenance of white supremacy is needed for most people who benefit from these systems to understand them and move towards committing to transformation. Of importance to note is that the cultural safety and cultural humility pedagogies employ a more critical lens than previous iterations of culturally-based approaches mentioned above. My concern with these approaches is, when explicit anti-racist pedagogy is avoided in favour of a culturally-based pedagogy, it allows learners to progress through training without deeply assessing their racial socialization or their understanding of culture. Cultural humility has the potential to encourage people to assess sociopolitical dynamics in every interaction, unless culture is only understood to pertain to ethnic performances or race. Culturally safe care and environments are extremely important and this stream of education, policy, and initiative is critical. And yet, I strongly believe that cultural safety will not be possible to attain without explicit deconstruction of the white supremacist ideology that people in colonial and post-colonial states are socialized into so that people fundamentally understand and become accountable for their (our) oppressive and/or privileged behaviour.

A major ongoing flaw in nursing education is the representation of race as biological rather than as a social construct, explicitly or not, which reproduces scientific racism in the form of deficit thinking about the Other. Race has been designated a social construct since the 1950's (UNESCO, 1952, as cited in Blanchet Garneau et al., 2018) and yet race continues to be

represented in health research and publications as a valid and biologically significant category (Allen, 2006; Gustafson, 2007). In the reviewed literature disease processes and affinity (see Baxter, 1998; Vaughan, 1997) and altered pharmaceutical metabolism (see Montenery, Jones, Perry, Ross, & Zoucha, 2013) are attributed to racial or ethnic categories of people. A further example from the literature at large is in an article about intersectionality and LGBT cancer patients (see Damaskos et al., 2018). This article does identify race as a social construct elsewhere in the article, but a paragraph about an increased risk of cancers in African American men fails to address its social construction and thus provides opportunity for students assigned this reading for its important contributions about risk assessment to uncritically absorb and then reproduce this biological perspective. Further, when race is used as a category but is used in a very specific and contextual way, it further confounds the issue. Health data that is specific to African American men but that is not generalizable to other men from the African diaspora cannot then be attributed to race and needs to be investigated and represented more responsibly. A study by Cooper et al. (2015) that demonstrates a lack of generalizability of hypertension risk in African diasporic people illustrates this point; they identify low social status in a multiracial society as the hypertensive risk factor. The increased risk of hypertension is related to social conditions associated with being racialized. Without a critical eye on the social determinants of health and an understanding of the cycle of race-based oppression, health inequities can appear to be a consequence of racial group membership in and of itself. Illnesses and health trajectories that appear to be associated with racialized groups need to be re-identified with their social or geographic pre-determinant so they are no longer associated with the false category of race and stop contributing to notions of fundamental race-based biological difference. Sickle-cell anemia, for instance, is an inherited blood disease whose prevalence is associated with geographic areas

with higher incidences of malaria (Luzzato, 2012; WHO, 2006) and with social behaviour such as endogamy and consanguinity (Piel, et al., 2012; Solovieff, et al., 2011). People originating from, or having ancestors originating from, malaria ridden areas are at higher risk of having sickle-cell because of the increased malarial survival rate of heterozygous sickle-cell carriers, and not at all because of their conceptual race (Luzzato, 2012). The risk is geographically and environmentally mediated and the trait or disease is passed genetically through reproduction; a person's perceived race is irrelevant. Little progress can be expected towards health equity and racial justice if beliefs about biological differences between groups of people along purported racial lines persist in our institutions. To reiterate, the reproduction of race-based notions of disease causality or affinity reproduces deficit-thinking about racialized people which can support implicit white supremacy. This can impact relationships with patients, but also relationships amongst educators and amongst students in the educational environment. Nurse educators have a critical role in intentionally and persistently addressing these inconsistencies in the literature and in discourse with nursing students in order to interrupt the unconscious acquisition or support of race ideology. Selecting literature for course materials that specifically attends to and disrupts these patterns of raciologic thinking will provide critical opportunities for undergraduate students to develop an anti-racist lens (see Browne, 2005; Browne & Varcoe, 2006).

Educational Climate

The climate in nursing schools is presented in this body of literature as isolating, discriminatory, and unsupportive towards staff, faculty, and students that are racialized (Baxter, 1998; Cortis & Law, 2005; Hassouneh, 2006; Hassouneh, 2013; Schroeder & DiAngelo, 2010) which leads to poorer recruitment and retention, poorer performance, and significant racial stress

and ill-health (Abrums et al., 2010; Alleyne et al., 1994; Beard & Julion, 2016; Cortis & Law, 2005; Schroeder & DiAngelo, 2010; Vaughan, 1997). White, Eurocentric raciological thinking promotes a deficit appraisal of people from outside of the normative categories (Beard, 2016; Beard & Julion, 2016; Hilario et al., 2018; Scammell & Olumide, 2012; Thorne, 2017; Van Herk et al., 2011; Vaughan, 1997). The education and cognitive capacity of internationally trained nurses and nursing faculty is frequently under question (Scammell & Olumide, 2012). Faculty struggle to advance to tenureship, report inequitable workloads, and unconscious bias in their white colleagues (Beard, 2016; Beard & Julion, 2016; Hassouneh, 2013). Both dominant faculty and students, and institutions actively resist acknowledging the need for anti-racism (Abrums et al., 2010; Beard, 2016; Cortis & Law, 2005; Drevdahl, 2001; Duffy, 2001; Hassouneh 2006; Holland, 2015; Scammell & Olumide, 2012; Schroeder & DiAngelo, 2010; Thorne, 2018). Institutions are charged with not supporting explicit anti-racist endeavours (Schroeder & DiAngelo, 2010) instead favouring non-performative and self-congratulatory department statements that take up the euphemistic language of diversity and inclusion (Ahmed, 2006). Institutional efforts at increasing representation of non-white identifying students and nursing faculty are notoriously unsuccessful despite what so much of the literature cites as 'increasing diversity' in the broader societal landscape (Schroeder & DiAngelo, 2010). "Recruitment and retention initiatives need to be redesigned in a manner that dismantles hegemonic and narrow views of what nursing entails and who is able to be a nurse" (Jefferies et al., 2018, p. 54). The climate of nursing's educational environments from the perspective of faculty is further represented in the counter-narrative section below.

Nurse Educators

Though literature searches about racism in nursing yield thousands of results, writing about nurse educators specifically is decidedly sparse. Only three of the reviewed articles explicitly name teaching anti-racism, while others take up varying approaches to improving health outcomes for marginalized people such as cultural competency, multiculturalism, diversity and inclusion, and challenging Euro-normativity; a comparison of which is beyond the scope of this paper. Articles with an explicit focus on nurse educators fall into one or more of several categories: impact studies following educational interventions; exploration of faculty teaching abilities and experiences; and counter-narratives that account for faculty experiences of racism.

Impact Studies

Beard (2016), O'Connor et al. (2019), and Tengelin and Dahlborg-Lyckhage (2017) report on the marginally positive impacts of three different professional development events. Beard's (2016) study analyzed the "multicultural attitudes, awareness, and practices of nurse educators" (p. 439) following a one-time training session in order to eventually diversify the nursing workforce. Though the discourse of multiculturalism is heavily critiqued for depoliticizing social inequities, what Beard (2016) relies on in her study is Banks' critical multicultural education framework that does address racism and other oppressions.

Beard's (2016) results from pre and post training Likert scale-based questionnaires demonstrate an improvement in awareness and attitude, but not in practice. The post-training questionnaire was conducted just one week after the training session which I do not believe to be adequate for educators to assess their own efficacy at making change in their classrooms. In reality many educators would have seen their students once in this time period and would have needed to assess and adjust their teaching materials. Logistically, these things take time. Interestingly the participants were drawn from predominantly white nursing schools, which are

81% white nationally (National League, 2020), yet only 40% in the study were white which provides tentative data about the willingness of white nurse educators to challenge the status quo. While everyone considered to be non-white make up only 19% of nurse educators in the United States (National League, 2020), they constituted 60% of participants in this study. If attendance can be construed as valuation of multicultural awareness, attitudes, and practices, then the stark lack of representation of white nursing faculty at this workshop as compared to their statistical representation may indicate that these are not priorities for white educators.

O'Connor et al. (2019) report on short-term outcomes following a 3-day "diversity, equity, and inclusion" (p. 633) event aimed to improve classroom inclusivity for an "increasingly diverse" (p. 633) student population. O'Connor et al. (2019) cite a need for transformational change to learning environments in nursing to mitigate reports of "microaggressions, bias, and/or exclusion" (p. 633) by students. They report that nurse educators feel unprepared to "address critical conversations on topics such as power, privilege, dominance, [and] institutionalized racism" (p. 634) and that white faculty are particularly challenged by conversations about racism due to their own racism and lack of abilities to facilitate challenging discussions. Despite identifying these critical needs, this study minimizes them by using power-erasing diversity and inclusion language for the intervention and focusing on content inclusion rather than embodied change. This notion will be further developed in another section. O'Connor et al. (2019) studied educators from one school of nursing and as such did not collect salient demographic information that would have revealed the identity of minority faculty in their data.

Impact of the voluntary, paid, training was assessed through participant evaluation of self-efficacy of diversity, equity, and inclusion related teaching at the beginning of the training and immediately following it and demonstrated a significant improvement in thirteen of the

seventeen items. The tool used in this study was adapted from another teaching context by adding the words "DEI content" to the end of each item which is vague and I argue will thus provide non-specific results; the authors do note the reliability and validity of this tool was not tested. Again, measuring impact immediately following learning does not provide participants the opportunity to attempt to apply the learning in live situations. Further, as self-efficacy is based on participants' beliefs about their ability, it cannot represent an authentic change in practice, and so I question the usefulness of this measurement, at least as a standalone measurement. The study claims its results are evidence of an intervention that "can create inclusive environments and address issues related to health equity" (p. 633) despite lacking any measurement of impact on students. It is possible that the questionnaire-measured impact does not represent the actual lived impact of participation and so without discounting the important work done during this three-day workshop, there is reason to critically inquire into who this type of data benefits.

Tengelin and Dahlborg-Lyckhage (2017) conducted a discourse analysis on focus group interviews of nurse educators following a voluntary sixteen-week course on norm awareness with the aim of improving nurse educators' abilities to translate this knowledge to students. Though the educators demonstrated growth in terms of awareness of societal norms and their impacts, it became apparent to the authors that their use of normative binaries and difference-as-deficit language demonstrated that the learning did not extend to a critical understanding of how the societal norms operate. The authors posit that the "norm-critical perspective is still immature" (p. 9) in nursing educators such that the traditionally noncritical and normative nursing habitus has yet to be transformed. This article does not provide data or analysis on the

participants' social locations beyond their membership as nursing educators in a single university college in Sweden.

As a minute body of literature, these three studies demonstrate that nursing educators' practice is difficult to impact despite an awareness of the need for change. These studies also provide meta-examples of research that reproduces the very structures they are working to change and point to limitations of research on sensitive topics; both of which will be taken up in the discussion section.

Faculty Abilities and Experiences

Nurse educators, especially white educators, are reproached in the literature for their lack of preparation and skill to address instances of racism in their classes and to teach a critical, emancipatory curriculum that addresses race, power, and privilege (Abrums et al., 2010; Baxter, 1998; Beard, 2016; Charbeneau, 2015; Cortis & Law, 2005; Dean, 2005; Hassouneh, 2006; Holland, 2015; Markey & Tilki, 2007; Nairn, Hardy, Harling, Parumal, & Narayanasamy, 2012; Schroeder & DiAngelo, 2010; Thorne, 2017; Van Herk et al., 2011).

Montenery et al. (2013) interrogate nursing educators' commitment to developing their own cultural competence, citing that nursing schools have no systems of accountability towards professional development. They identify longstanding segregation, a lack of skills in recognizing stereotypes in course materials, and a null, or absent, curriculum as contributing to nursing educators' lack of cultural competence. The authors note a dearth of literature focused on nurse educators' competence.

Though Markey and Tilki (2007) are grounded in transculturalism, they address racism directly in their article about Markey's development as an educator. They note that "fear, guilt, and uncertainty lead lecturers to avoid painful or threatening issues" (p. 391) in the classroom

and that “continued professional development opportunities are needed to enable lecturers to explore the issue of racism, addressing their ethnocentricity as a precursor” (p. 393) to engaging with students. Markey and Tilki (2007) expose an uncritical understanding of racism that is missing the analysis of power in a racial hierarchy; their grounding in transculturalism negates a clear distinction between the social constructs of race and culture.

Educators in the Nairn et al., (2012) study are not confident in their abilities to intervene in racialized conflict between students for a lack of language and facilitation skills. As a group, they are not able to define cultural diversity. They are concerned about feeling uncomfortable, so much so that they avoid talking about race and racism. They allow their whiteness to have Foucauldian disciplinary power by censoring themselves so as to not be labelled politically correct. They worry their positionality as white, middle class people will make intervention problematic; one lecturer claims she does not think she could be taught to “manage those things” (p. 206) and that no one had ever shown her how. Another lecturer admits to assuming other courses would cover the content. The challenges identified by these nurse educators demonstrate a lack of skill, a lack of critical awareness of race and racialization, a lack of accountability to educate themselves and their students, and privileged fragility.

Holland’s (2015) study of the lived experience of white nursing educators teaching about race reveals the impact of the null curriculum of race in nursing. The study interviews experienced educators of culturalist content and identifies a lack of conceptual understanding of racism and institutional racism, avoidance of race-based classroom dialogue for fear of conflict, and unconscious racialized language use that perpetuates the white/non-white binary.

An eye on the discourse of the above articles exposes the complexity and difficulty of a profession examining itself, and perhaps more saliently, of a privileged social location examining

itself. Montenery et al. (2013) unknowingly reveal a self-congratulatory discourse while reviewing studies measuring cultural competence. Results of one study showed that only 39% of faculty were deemed competent and yet the results were still interpreted as confirming faculty commitment. Rather than a critical appraisal of the impact of non-oppressive care, Montenery et al. (2013) use vague rhetoric as motivation for change: impacts can be "positive and meaningful" (p. 52); "the reward is great in the end" (p. 53); and the "rewards are innumerable" (p. 56). Cultural competence, safety, and humility are described in absence of discussion about dominant norms, ethnocentrism, racism, or other oppressions. While this article is significant in its critique of accountability in both educators and nursing institutions, and in naming the responsibility nurse educators have to be competent, it is an example of de-racialized and essentialist culturalism that supports processes of Othering and reproduces race as biological.

Nairn et al. (2012) demonstrate the absent presence of whiteness. The participants' whiteness is acknowledged cursorily but not interrogated as an influence on the results of the study. All eight interviewees in their study are white but their lack of racial literacy is not correlated to their social location. Whiteness is seen but its impacts as a social location with specific social affordances are erased; it is present, but absent at the same time. The authors regularly employ euphemistic language about racism and oppression, often not even with coded signifiers but with vacant phrases such as cultural issues, issues related to racism, the topic, the issues, and problems associated with racism. Diversity is used in place of any critical discussion of racialization and racism. Lecturers need to 'manage' issues of cultural diversity, the language of which pathologizes diversity rather than ethnocentrism or xenophobia. More direct language would communicate a critical understanding to the reader.

Nairn et al. (2012) conclude that the educators and their nursing institution "take the topic seriously" (p. 207) despite the data being devoid of action-based responses, and claim that nursing educators need assistance to gain competence; both of which avoid asking nursing educators to take accountability for their skill level. Holland (2015), on the other hand, specifically aims to interrogate the preparedness of white nursing educators to teach adequately about race and racism. Among Holland's calls to action is a personal accountability in all nurse educators, but especially cultural content experts, to familiarize themselves with the anti-racism literature and develop the requisite skills.

What might be seen as protectionism in the Nairn et al. (2012) article, is responsibly absent in Holland's (2015), and is explicitly named as white active resistance in the studies discussed in the following section. Notable is the change in tone in these studies, where the research and writing are supported by personal experience in a racialized standpoint.

Counter-Narratives

Critical race theory recognizes the power of narrative to reinforce or to deconstruct a worldview (Delgado & Stefancic, 2001). Existing social grand narratives function to maintain the racial hierarchy, usually implicitly, through processes of socialization and invisible systems of privilege. As such, it is difficult for members of the dominant social group to understand lived experience from a different standpoint, as evidenced in some of the above literature where white students and faculty are unable to sustain discussions about racism. Counter-narratives are stories of lived experience from outside of the dominant milieu that work to rattle the foundation of dominant narratives (Delgado & Stefancic, 2001); the following literature works in this way.

Hassouneh et al. (2012) report on patterns of behaviour by dominant group faculty; making explicit and naming patterns of behaviour experienced by faculty of colour serves to

construct a narrative that would likely never originate from a white faculty perspective. Hassouneh et al. (2012) interviewed twenty-three nursing faculty members from predominantly Euro-American schools of nursing whose experiences coalesced into a theory of exclusion and control. White faculty are understood to defend the white dominant status quo in nursing schools through processes of invalidation, Othering, isolation, unequal standards and access to resources, silencing, and tokenism (Hassouneh et al., 2012). These processes exist despite professional, departmental, and institutional claims to foundational values of equity and diversity. Hassouneh et al. (2012) also identify a process of socialization between faculty members and faculty to students that works to reproduce these patterns of behaviour.

In a journal editorial Hassouneh (2013) more explicitly names unconscious racist bias in European-American nursing faculty. "Focusing on unconscious bias means looking at the ways stereotypes are embedded in the cognitive processes of nursing faculty" (Hassouneh, 2013, p. 184) drawing attention to the "several hundred-year hegemonic legacy of racist conditioning" (p. 183) that colours their lenses of perception. Hassouneh urges white faculty to work towards awareness of their unconscious biases in order to change racist systems of exclusion that maintain the underrepresentation of faculty of colour. According to Hassouneh (2006) many white faculty are "comfortably oblivious to the realities of racism" (p. 260) and resist efforts of their peers to move issues of racism and Eurocentrism in the faculty forward.

Hassouneh (2006) provides a personal account of the challenges of engaging in anti-racist pedagogy in predominantly white schools of nursing as a racialized educator. Years of teaching anti-racism to resistant students in unsupportive institutional environments decreased her willingness and ability to authentically engage with the pedagogy. Hassouneh (2006) describes how the existing racial hierarchy and power relations of the broader society are reflected in the

classroom which exposes students and faculty to overt and covert racism from non-racialized students, despite the fact that she is otherwise in a position of power over the students. Hassouneh (2006) reports being "slowly silenced by ongoing anti-racist pedagogical resistance and racist attacks" (p. 258) from white people, and that she sees this pattern of being silenced in her students as well.

Beard and Julion (2016) conducted an inquiry into whether race still matters in nursing through interviews with twenty-three African-American faculty members about their lived experiences of working in academia. The resulting narratives include desires to enter academia to add their marginalized voices to policy, nursing care, and education initiatives, and to support and mentor upcoming students. The experiences of these faculty members however included invalidation, marginalization, racism, prejudice, and overall, an unsupportive work environment. The introduction to their article states that "faculty members' narratives could affirm or challenge old beliefs, create new truths, and engender academic environments that support greater diversity" (Beard & Julion, 2016, p. 584) and that narrative inquiry is used to further "our understanding of relationships between individuals and their environments" (p. 584). Together these statements seek to provide a counter-narrative that is contextualized in academic nursing environments to challenge normative discourse.

Discussion

The silent discourse between these faculty-focused articles is illuminating. There are studies towards incremental change by teaching skills that are non-specific to racism and often do not include a racial analysis of their participants to deepen the discussion of implications and make pointed recommendations. There is literature documenting the ineffectiveness of white nursing faculty in talking about, teaching, or challenging racism in their classrooms and their

confessions that they avoid this responsibility to avoid feeling uncomfortable. Then there is literature that is waving a flag, imploring that the focus be reassessed and that white nurse educators be held accountable for their complicity in upholding white supremacy and continuing to actively dominate academic nursing spaces. Despite good intentions and a growing body of critical nursing literature that demonstrates racial literacy and responsible reflexivity, it seems we, as a group of mostly white educators and scholars, are still missing the mark.

The literature exploring or seeking to improve teaching practices externalizes the focal point of change to skill or knowledge acquisition and confines the intentional impact to faculty-student relations. Classroom strategies alone are not sufficient change when fundamental socialized behaviour and ideology are the culprits. Further, those studies do not interrogate intraprofessional dynamics and thus are complicit in supporting the status quo in nursing faculties and sidestep the fact that society's racist organizing principles pervade every environment. White faculty in these studies illustrate a desire and willingness to maintain the status quo by admitting they do not take on anti-racist practice because they do not want to be uncomfortable. These admissions do not acknowledge the persistent discomfort their colleagues endure while working in hostile environments and they incriminate white faculty for avoiding racial justice for their own benefit.

Both Beard and Julion are African-American nurse scholars who, according to their own study, presumably have personal experience with discriminatory work environments, yet they chose to frame their research as an interrogation of the ongoing presence of racism and excluded themselves from the study. Does the unspoken discourse of those decisions speak to a need for strategic creation and dissemination of data through the hegemonically valued ideal of objectivity to enact change in the nursing discipline? Both studies by Hassouneh et al. (2012) and

Beard and Julion (2016) identify invalidation as a common experience for racialized educators. Is there a need to act subversively to safely expose counter-narratives in nursing?

An example from the literature of an initiative that addresses the oppressive climate and culture of a school of nursing with aims to more broadly effect change than the acquisition of individual classroom skills is the Sociopolitical Climate Project at the University of Washington (see Schroeder & DiAngelo, 2010). Explicit project goals of collaborative and sustainable work towards challenging the "status quo of unnamed white privilege and racial injustice in nursing education" (p. 244) focuses engagement on root causes of injustice and does not permit nebulous conceptualizations of difference nor does it encourage the diffusion of oppressive circumstances through the use of vague language such as diversity and inclusion. A result of this initiative was the development through primarily self-reflective positions to action oriented anti-racist behaviour in the participants (Schroeder & DiAngelo, 2010). The authors report this finding as critical to their assessment of success because antiracism does not manifest in reflection, it only operates through action.

Literature that fails to include a critical analysis of its participants in relation to the study outcomes or discussion are disregarding the potential to draw meaningful conclusions about relational and systemic enactments of power. Studies taken up in contained groups of nursing educators with ongoing professional relationships must consider the safety of the participants, especially those at the margins who may be identifiable in the data by their demographics. This research limitation is a direct result of the poor representation of racialized educators in these spaces and unfortunately contributes to an aracial analysis in these studies about racism, effectively omitting an important level of social analysis and producing data that reproduces colourblindness. Where analysis of social location is not possible or not taken up, the

particularities of personal accountability can be missed. Broad and general strategies such as diverse content in classrooms do not demand rigorous self-examination and can permit an externalization of the problem. Policy, initiatives, studies, and education that permit an externalization of the locus of responsibility for the reproduction of the racial order are continuing to throw more of the same ineffective methods at the symptoms of a problem rather than zooming in on the problem itself. Nearly half of the reviewed literature identified a critical need for nurse educators to address their ineffectiveness at teaching a critical anti-racist pedagogy, and while not all of the literature took up an intra-study racial analysis, those that did found that in white nurses lies a problem. Three studies explicitly called for accountability in nurse educators towards their own professional development of not only anti-oppressive pedagogical tools, but more importantly of transforming their uncritically white-normative and racially domineering habitus. This is both personal and professional work that will require significant institutional support and authentic personal engagement for the long term.

Both Holland (2015) and Hassouneh (2006) are concerned with the ability of white faculty to adequately teach anti-racism and yet Hassouneh (2006) also sees the role of white allies as indispensable towards encouraging white students to "become allies who will speak and act against systems of oppression and challenge other white individuals to do the same" (p. 260). A commitment to developing an anti-racist identity that manifests in anti-racist pedagogy with students and non-domineering, non-racist, and supportive collegial relationships relies fundamentally on a commitment to humility, vulnerability, and relentless reflexivity. While there certainly exists a range of racial literacy and anti-racist development in nursing educators as evidenced by the studies about nurse educators and the critical anti-racist nursing scholarship referenced in this paper, many of us racially privileged educators, as Dean (2006) found through

his international cultural immersion experience, will be learning alongside, or from, our students. Especially where authentic expertise lacks, modelling humble, reflexive, and accountable engagement with anti-racist and anti-oppressive pedagogies broadly can provide inexperienced students a framework for their own engagement.

As introduced earlier, cultural humility as a guiding principle offers a descriptive or demonstrative conceptualization of embodied anti-oppression whereas cultural safety names the goal of such behaviour. I value these approaches for their work towards diminishing violence and discrimination towards marginalized groups, and Aboriginal people specifically, and yet I maintain that without explicit anti-racist pedagogy embedded in these approaches, deeply held and often unconscious racist ideology will persist. Consequently, I resist the use of the term 'cultural' in approaches meant to address all manners of oppression because of the propensity of society to conflate culture with race, ethnicity, and difference broadly rather than understanding culture to be the values, norms, and expectations of any social field (see Bourdieu & Wacquant, 2013 for more on social fields and habitus). Until the common understanding of culture extends beyond narrow conceptualizations of Othered ethnicity and we can trust our nursing students have or are developing a broad and critical understanding of culture, I argue for the application of more direct and explicit language to describe and attend to the specific oppressions we seek to disrupt. Further, in the contexts of many cultural safety and cultural humility pedagogical sessions in healthcare participants engage with the material only briefly, sometimes over just a few hours a year in mandatory training, and therefore may not have, or take, the opportunity to move beyond superficial understandings of these concepts. I base these arguments on my own racial literacy development and that of the students I have witnessed over the last six years and though important, further discussion of these ideas is beyond the scope of this paper.

Finally, the application of the critical anti-racist, anti-discriminatory, post-colonial, and intersectional perspectives that have been theorized or contextualized by nurse scholars for the nursing profession (see Blanchet Garneau et al., 2018; McGibbon & Etowa, 2009; McGibbon et al., 2014; Van Herk et al., 2011; Walter, 2017) relies on the abilities and literacy of nurse educators. Where critical perspectives are present in curriculum and in assigned course readings, the depth to which students understand and take them up in practice will certainly corelate to some degree with the extent of familiarity and comfort their nurse educator has with the material. While the few studies on nurse educators reviewed in this paper cannot represent all educators, they do provide evidence that some nursing educators are not prepared to adequately deliver this content, nor embody its precepts.

Conclusion

The calls to action from across all of the reviewed literature presents some clear themes for further development through research and action. First, many authors implore nursing educators and scholars to reimagine nursing curricula in a decolonized, critical, emancipatory paradigm (Allen, 2006; Blanchet Garneau et al., 2018; Browne, 2005; Browne & Varcoe, 2006; Fahrenwald et al., 2007; Holland, 2015; McGibbon et al., 2014; Puzan, 2003; Tengelin & Dahlborg-Lyckhage, 2011; Van Herk et al., 2011; Walter, 2017) which is certainly underway in many nursing schools. Comparative studies of the method and impact of thorough curricular integration of critical social theories will benefit all schools looking to transform their content to adopt a social justice lens. Innovative instruction and evaluation methods are called for towards a decolonized nursing education that does not reproduce dominance and competition. Processes that disrupt the hegemonic devaluing of social and relational content in favour of biological and psychomotor content would also be worth documenting and disseminating. Racism and other

oppressions need to be conceptualized as equally harmful to patients as any other form of harm, and individual accountability for attending to these risks needs to be a priority in nursing education. An intersectional risk assessment could become another vital sign. Where education is delivered in a politically 'safe' manner, we must interrogate who this safety protects, and who it harms.

Second, there is a call to authentically and fearlessly account for the ongoing systemic, institutional, and interpersonal racial discrimination in our social systems, and in nursing in particular, that is upheld by a system of white domination as a result of imperial colonialism. Developed in this paper are arguments for a redirection, or increased attention at least, towards dismantling the status quo of unnamed white dominance both relationally and in numerical representation in nursing education through research and institutional initiatives. Studies done with white educators demonstrate the need for significant personal and professional investments in the development of racial literacy and explicitly anti-racist perspectives, and that initiatives towards developing skills more readily impact awareness than practice. Competent white educators are needed to deliver consistent anti-oppressive pedagogies and to role model positive white identities for white students. Studies that provide counter-narratives demonstrate the persistence of racial harm and identify how privileged whiteness and white supremacy are maintained in educational settings. Future research endeavours should include analyses of participant's social locations to identify socially constructed discourses and provide data that does not reproduce colourblind ideology. An evaluation of progress and initiative in other healthcare or educational professions towards dismantling white supremacist systems and behaviour could be worthwhile. Results of anti-racist or anti-oppressive initiatives could more accurately reflect impact by focusing measurements on action-based changes, especially in the

long-term, rather than short-term measures of self-efficacy and researchers should consider whether the framing of their results is protective of white privilege. The development of anti-racism in white nursing educators specifically needs to be directed as much, if not more, to our internalized white supremacist ideology and persistent racial privilege as it is to the development of pedagogical skills. Dena Hassouneh tells us that "these efforts require a commitment of time and energy and often involve discomfort (de Sherbin, 2004); yet, facing and enduring this discomfort in solidarity with people of color engaged in anti-racist struggle are absolutely essential to social change" (2006, p. 261). It is past time to tackle the root causes of racial oppression and resulting inequities with authenticity and humility rather than attempting to treat just the symptoms.

2.2 Whiteness as a barrier to anti-racism in nursing education

Abstract

A recently completed literature review reveals key trends of White dominance in nursing education and scholarship. Overall, the review establishes that enactments of Whiteness work to maintain White dominance in nursing education and prevent nurse educators from taking accountability for engaging in anti-racism despite an ethical and professional requirement to do so. Schools of nursing in Canada have received a call to action to deliver anti-racist education yet it is questionable how effective the profession can be at this endeavour. Nursing education in predominantly White colonial countries is criticized as being a hegemonic space that reproduces White normativity through curriculum, instruction, and faculty representation. Whiteness is described in the literature as an ideology, an ethnic performance, a discourse, and a system. This paper develops how the ideology and enactments of Whiteness in the nursing education milieu, employed by White nurses, function as barriers to anti-racism.

Keywords: Anti-racism, Ideology, Nursing education, Nurse educators, Whiteness

Whiteness as a Barrier to Anti-Racism in Nursing Education

White domination in Canada and other countries is the legacy of colonial imperialism and is founded on ideals racism and Eurocentrism (E. McGibbon et al., 2014). A consequence of colonialism is an ongoing ideology of White superiority; an ideology with varying opacity over time. Nursing has developed alongside and worked amidst this colonial domination and cannot evade social influence (E. McGibbon et al., 2014) despite a propensity of the profession at large to deny the presence of dominating relations in its midst (Scammell & Olumide, 2012; Vaughan, 1997).

Nurses in Canada and the United States largely are White people (Abrums et al., 2010; Beard, 2016; Cortis & Law, 2005; Hassouneh, 2006, 2013; Markey & Tilki, 2007; Schroeder & DiAngelo, 2010; Van Herk et al., 2011) and this dominance gives White nurses the unconscious privilege of identifying with their professional role while overlooking their role in a racial hierarchy. Concomitantly, nursing education is criticized for working from an apolitical lens that serves to erase race and socially mediated disparities (Alleyne et al., 1994; Blanchet Garneau et al., 2018; Cortis & Law, 2005; Fahrenwald et al., 2007; Hassouneh, 2006; Holland, 2015; Markey & Tilki, 2007; Walter, 2017). For example, race continues to be represented as a valid biological category in nursing research and literature (as example see Baxter, 1998; Montenery et al., 2013; Vaughan, 1997) despite decades of scholarship and global initiatives to deconstruct this notion. Additionally, the climate in nursing schools is reported to be isolating, discriminatory, and unsupportive towards staff, faculty, and students that are racialized (Baxter, 1998; Cortis & Law, 2005; Hassouneh, 2006, 2013; Schroeder & DiAngelo, 2010). This challenging climate contributes to poor recruitment and retention of non-White identified people at all levels, and significant racial stress (Abrums et al., 2010; Alleyne et al., 1994; Beard &

Julion, 2016; Cortis & Law, 2005; Schroeder & DiAngelo, 2010; Vaughan, 1997). Nursing has a tragic problem.

The impacts of racial domination and racial discrimination and oppression extend far beyond the reaches of nursing education. Health care has been identified as an institution that not only neglects to attend to some groups of people, it also explicitly harms them. The Truth and Reconciliation Report (National Center for Truth and Reconciliation, 2015) expressly names nursing education as a site of needed transformation. Two of the calls to action involving nursing are education for cross-cultural care, and anti-racism. These calls ask that nursing dismantle its Eurocentric and biomedical cultural hegemony and to dismantle internalized and systemic expressions of White racial superiority. And so I wonder, is a profession dominated by people who benefit from systems of superiority capable of dismantling them?

A broad look at literature on anti-racism, anti-racist pedagogy, privilege, and whiteness in nursing education and on nurse educators proved a revealing study of progress and resistance over time, of self-incriminating discourse, and of a profession battling itself to become a site of justice rather than oppression. Demonstrated below through nursing and some peripheral literature on Whiteness is how the ideology of Whiteness is enacted and works to maintain White dominance in nursing rather than attend to anti-racism as we have been called to do. In this paper, I focus on Whiteness because I do not believe that skills-based education purporting to decrease discrimination gets to the heart of the matter; they permit a continued externalization of the problem. Our deeply engrained socialization and the conventions and institutions that support it need to be challenged. Not taken up in this paper is an intersectional analysis of how Whiteness in nursing is enacted differently across social standpoints.

Positioning Myself

I am a White descendant of settlers from England, Ireland, Scotland, and Greece and am of Western Canadian ethnicity. I was born and raised on Treaty 7 territory in a privileged family and in an unsurprisingly racially segregated, semi-rural community. I am a registered nurse and a nurse educator in WSANEC, Esquimalt, and Songhees territory, which is colonially known as Victoria, British Columbia. I have taught in four nursing schools in British Columbia in various capacities and in both baccalaureate and practical nursing programs. I have, admittedly, taught anti-racism very poorly in the past.

I focus on nursing education because I see the enormous responsibility we have as educators to stop graduating people into the profession that will uncritically and often unknowingly participate in the oppression of racialized and marginalized people. I am inspired by the potentially exponential effect nurse educators could have on racialized disparities in health care if each anti-racist educator could impact dozens or a hundred students, who in turn could impact hundreds of patients.

Before discussing the literature, I want to define several key terms. Following Schroeder and DiAngelo (2010) I adopt the contextual definition of racism as "…structures, actions, and beliefs that systematize and perpetuate an unequal distribution of privileges, resources, and power between white people and people of colour" (p. 245). The key here is acknowledging the complex involvement of societal structures and systems in maintaining and reproducing racial inequality and inequity; that enactments of superiority are backed by institutional power (DiAngelo, 2012). Racism is a system and people without institutional and systemic power behind them are unable to benefit from racism. This definition supports my focus on Whiteness, as people who are White-identified have racial power and privilege and thus have work to do towards justice. A definition of anti-racism then, is action towards dismantling structures,

actions, and beliefs that maintain and reproduce racism. I also freely use the term White supremacy, which likely will be uncomfortable for some. I use this intentionally to draw attention to the fact that feelings, beliefs, enactments, and policies that incite any notion of inferiority towards non-white identifying people is White supremacy, no matter how insignificant they appear to be.

Literature Search Methodology

This paper reflects a subset of a larger literature search completed in the spring of 2020. Using Summon 2.0, the research tool of the University of Victoria's library catalogue, I searched in various combinations: nurse education; nurse educators; nursing faculty; nursing curriculum; racism; anti-racism; anti-racist pedagogy; privilege; whiteness; and professional development. Articles were first selected for obvious connection to the themes of racism, discrimination, critical social theories, and anti-racist pedagogy, and subsequently narrowed down to articles about nursing faculty and Whiteness. The ancestry method was used to locate further relevant literature, and several sources were included for relevance from the authors collection. From a total of 136 peer-reviewed articles, books and book chapters initially selected for review, 46 were selected for the larger literature analysis project, 32 of which are included in this paper. The literature I have reviewed is almost exclusively from Canada, Australia, the USA, and the UK. This situates the analysis in colonial states where power and privilege are inarguably concentrated in people who are White-identified.

Whiteness as Ideology

Whiteness is described in the literature as an ideology (DiAngelo, 2012) a discourse (Gustafson, 2007), a system (Gillespie et al., 2002), a location (Puzan, 2003; Schroeder & DiAngelo, 2010), and an ethnic performance (Allen, 2006; Schroeder & DiAngelo, 2010). While

nursing literature is rife with theoretical description and development of other racial categories, it is criticized for its lack of analysis of Whiteness (Charbeneau, 2015; Puzan, 2003). Just as the avoidance by culturalist discourses of explicit discussions of race relations evades the transformation of race-based inequalities, so too does the avoidance of naming Whiteness evade transformation of White dominance in nursing. To the degree that knowledge obscures power relations, it is ideological (Sprague, 2016). If nursing discourses and theory do not address racial relationships in the profession, they do so to the benefit of those at the center.

The lack of attention and self-awareness speak to the invisibility of White ideology in nursing and scholars describe this invisibility as a source of ongoing power (Gillespie et al., 2002; Gustafson, 2007; Puzan, 2003; Schroeder & DiAngelo, 2010). Whiteness derives much of its authority and power through its invisibility by maintaining its presence as neutral, objective, and apolitical (Gillespie et al., 2002; Gustafson, 2007; Scammell & Olumide, 2012). Whiteness is considered the norm, or as Puzan (2003) describes as the "unexamined substrate" (p. 194) against which everything else is defined. This coincides with nursing Euro-normativity which leaves White people both raceless and cultureless (Gustafson, 2007; Puzan, 2003; Schroeder & DiAngelo, 2010). Thus, spaces such as institutions or even curriculum dominated by White people are understood to be absent of racial and cultural ideologies; they are considered neutral (Allen, 2006; Scammell & Olumide, 2012; Schroeder & DiAngelo, 2010). If institutions and curriculum are neutral, then people, ideas, cultural expressions, and needs that do not fit the norm are deviant. This supposed neutrality feeds discourses of deficit and inferiority. When people who do not benefit from the social and structural benefits of Whiteness experience differential health, wealth, or otherwise determined success in these spaces they are judged to be failing in some way. Similarly, this mistaken neutrality feeds the discourse of White merit; the

notion that people who do benefit from the social and structural benefits of Whiteness are healthy, wealthy, and successful because they have worked hard and earned their rewards (Schroeder & DiAngelo, 2010).

What this looks like in nursing education is the uncritical acceptance of a racialized student failing an exam about racism rather than exploring what invisible and hegemonic features acted as barriers to her expressing her held knowledge. It can also look like the creation of elite grade categories where only students that exceed assignment expectations can receive full marks for the assignment. Students with the resources to support their extraneous effort on school work such as finances, childcare, social support, and cultural capital, are better able to meet this unnecessary goal. This is a system that uncritically privileges the privileged, reproduces the notion of merit, and literally works to keep less privileged people at a lower rank. The liberal discourse of individualism is a key component of White ideology. Individualism attributes outcomes to individual actions and efforts rather than examining social structures and relations or the unexamined substrate of White normativity. Focusing on individual behaviours or perceived abilities erases social causes of disparity and protects the invisibility of dominating forces.

Naming Whiteness then, is an act of resistance (Allen, 2006; Puzan, 2003; Yancy, 2012) that makes visible "a set of relations that are historically, socially, politically, and culturally produced, and that are intrinsically linked to dynamic relations of White racial domination" (Schroeder & DiAngelo, 2010, p. 245). Naming the maintenance of White supremacy as the locus of racial oppression permits a focus on the source of the problem rather than the widespread injustice it creates as symptoms. Allen (2006) identifies that the power to name and describe is not equally distributed; in the raced and gendered colonial environment this power

has traditionally rested in the hands of White men. Allen (2006) and other authors (DiAngelo, 2018; Gillespie et al., 2002) identify surprise, resistance, and even offence in White people when they are raced or otherwise ethnically described. White people have been socialized by the ideology of Whiteness to exist as the objective center and can be deeply challenged by the notion that their Whiteness is an observable ethnic performance (Allen, 2006). Nursing organizations have had an important opportunity to critically name dominant and problematic Whiteness in our institutions as a focal point for transformation in response to the demonstrations for racial justice over the violent deaths of Black men and women at the hands of police and other White people. While some organizations have clearly denounced systemic and violent racism and importantly committed to action, many nursing organizations' statements during this painful moment have fallen far short of accountability for nursing's own complicity.

Enactments of Whiteness

Schroeder & DiAngelo (2010) assert that Whiteness is "enacted moment by moment on individual, interpersonal, cultural, and institutional levels" and is described as a function of Bourdieu's concept of habitus: "a response or condition produced and reproduced by the continual social and material advantages of the white structural position" (pp. 245-246). The invisibility described in the above section is reproduced through the denial of dominance and assertions of neutrality and benevolence in nursing. This is evidenced by the lack of literature analyzing Whiteness, the lack of explicit learning outcomes in curriculum that challenge dominance, the uncritical uptake of culturalism, and the equal treatment discourse in both nursing education and practice.

In order for Whiteness to maintain itself it must continually, but silently, define itself by what it is not (Gustafson, 2007). The binary language of White/non-white, or of-colour, are

essentialist labels that produce an oppositional identity in a system of domination and subordination (Gustafson, 2007). This enactment requires that people be labelled with an identifier that distinguishes them from Whiteness such as: marginalized; minoritized; people of colour; non-White; foreign; diverse; ethnic; or any racial or national label. This very piece of writing in attempt to demonstrate White dominance in action both necessarily and problematically employs this racialized binary language.

Both Puzan (2003) and Gustafson (2007) expose an entitlement to a choice about acknowledging and engaging with White privilege and domination. Maintained hegemony in institutions and other places of power means White people are not obligated to face themselves as racialized beings in the way that other people cannot avoid. The literature demonstrates this element of choice repeatedly in the use of if/then statements that attempt to serve as appeals to nurses' morals: *'If nursing wants to improve … then we must …'* . Framing anti-racism and accountability as optional works to discredit the sincerity of the authors' commitment to change, and highlights the fact that transformation towards racial equity is not a given. Scholars are using these virtue signalling statements to appeal to nurses to reject the entitlement of choice.

An example of institutional socialization to the entitlement of choice is the ongoing labelling of particular nursing curricular content as *fluff* as opposed to *real* nursing knowledge (Thorne, 2018); in my experience the content deemed fluff is that concerning how humans relate to one another and is precisely where privilege and domination are discussed. When denigration of content is modelled to students by other students or by faculty, students are offered the choice to value the material or not. I graduated from nursing school seventeen years ago and the same content that was fluff in 2003 is still considered fluff now; this is a system of privilege and ignorance reproducing itself. Another example is the modelling of avoidance of learning

outcomes related to Indigenous health by faculty who are uncomfortable or unknowledgeable about how to apply them.

A powerful component of White nursing culture is its hegemonic valuing of scientific epistemologies, which in part contributes to the idealization of some nursing knowledge over other as described above. Nursing has long worked to legitimize itself as a profession through its devotion to empirical knowledge to the exclusion and delegitimization of other knowledges, despite a rhetorical claim to embrace diversity (E. McGibbon et al., 2014; Puzan, 2003). The emphasis on professional legitimization is connected to the gendered oppression experienced in nursing as a predominantly female component of the health care system. This ongoing emphasis on gendered oppression and professionalism, even subconsciously, to the exclusion of other oppressions is another enactment of Whiteness such that the experiences of the nursing elite, who are predominantly White, do not represent the society at large (Gustafson, 2007; Puzan, 2003). Puzan (2003) further describes the disciplinary power of Whiteness in nursing that requires nurses to "adhere to the behaviours, values, beliefs, and practices of the dominant White culture [in order to achieve] full assimilation into the nursing establishment" (p.195) and reports disapproval and marginalization of any nursing faculty deemed to have politicized behaviour.

Puzan (2003) also identifies enactments of White colonial domination in the self-serving and even exploitative relationships nursing schools have with community placements where the learning needs of students are the highest priority which often leads to an objectification of community members. Likewise, Yancy (2012) identifies outward anti-racist activism by White scholars who nevertheless continue to operationalize White privilege and dominance in the academic setting with their students and colleagues. Institutional and faculty resistance is well documented in the literature on nurse educators (Beard & Julion, 2016; Hassouneh et al., 2012;

Schroeder & DiAngelo, 2010) and is further described by DiAngelo (2018) as a suite of racial tactics that serve to sustain the racial order, including highly emotional and wounded displays that make it difficult for resistors of White dominance to navigate.

Charbeneau (2015) argues that educators primarily enact their Whiteness pedagogically through their "expectations of white students and students of color, curricular choices, … organization of the classroom, conduct of student assessments, and use of particular teaching approaches or tactics" (p.656). Where Whiteness remains invisible it remains unchallenged. If nurse educators do not examine themselves, their content and evaluation strategies, their classrooms, and their relationships for silent but hegemonic ideology they cannot see where to target their disruption.

Each of these enactments of Whiteness, which presumes entitled domination, negates the ability of nurse educators to be effective anti-racist practitioners and educators. Binary language reifies divisions among people along socially constructed racial lines, protecting a notion of 'us' and 'them'. Reproducing the entitlement to a choice about engagement in education or deconstruction of the racial hierarchy protects White privilege and enacts White supremacy. Uncritically valuing the scientific and psychomotor nursing knowledge above all else delegitimizes essential knowledge about sociopolitical structures that grievously impact health. And if White educators take up projects that assess or address racial inequities but do not extend the same analysis to themselves and their relationships, then they will likely continue to oppress.

White Dominance in the Literature: Writing to Whiteness

There are meta-examples of ongoing complicity with White dominance in the literature that merit scrutiny. Not all, but many articles that address racism and discrimination open with reports, or claims, that validate the presence of said injustice. While I understand this to be

standard academic process, the work of introducing the reader to the context of the writing, the presumed need for validating statements acknowledges the potential for dispute. Opening articles about racism with validating statements implies the academic community is, to date, unconvinced. If we consider the relevance of audience, and imagine an academic audience of people that do not benefit from systems of White superiority, validating statements about the existence and systemic impacts of racism would be unnecessary and perhaps even obtuse. The underlying influence then that dictates the language and structure of academic articles is White dominance; the audience is assumed to be predominantly White.

A related dominant discursive practice is the centering of Whiteness through racialized binary language (for example: Baxter, 1998; Vaughan, 1997). Non-racialized nouns such as nurse or faculty or student are assumed to represent White people, and racial signifiers are used to represent the Other: a Black nurse; Indigenous faculty; or Asian-American student. This practice, when unnamed, reproduces White as the normative body.

The language of diversity and inclusion is similarly problematic, as it continues to assume and reproduce White dominance at the center. Diversity of what? And when diversity is represented as a challenge, for whom is it a challenge? Where does the source of conflict actually lie, externally in something called 'diversity' or internally in the ideology of Whiteness that relies on dominance to sustain itself? Likewise, inclusion implies ownership over an arena with the power and choice to include or exclude. As similar to the notion of tolerance, inclusion implies permission has been given to enter a space belonging to another, rather than working to change the sense of ownership of the space itself.

Lastly, and related to the use of statements to validate racism, is the claim that patient and student populations in Canada, the UK, and the United States are becoming 'increasingly

diverse' which is used as justification for progress towards non-oppressive nursing practices (Abrums et al., 2010; Nairn et al., 2012; O'Connor et al., 2019; Xu, 2008). The notion that increasing diversity is motivation for change indicates that the current or past level of diversity was not motivation enough to provide non-oppressive care, that diversity was lacking, or disturbingly, that the nursing profession recognizes it can no longer get away with its oppression. Any notion of homogeneity in these nations erases Indigenous people and all descendants from other parts of the world that have been a part of the national makeup for centuries. These claims used as valid motivation for growth also erases the century of violence that people have experienced in health care settings. This discourse engages the language of diversity uncritically; it does not answer to whom the diversity is measured against, nor what entails that diversity. Is there a reason the bodies that make up the incoming diversity are valued more than those that currently exist as outside of the norm? Again, to the extent that claims avoid analyzing power, they are ideological (Sprague, 2016).

Conclusion

How can the White hegemony of nursing education be disrupted? We should be focused on disrupting the status quo not only because we have been called on as a profession to be better, but also because we understand that domination breeds injustice. Even at our own expense (White privileged people like myself), because anything else reproduces and protects the privilege that benefits us over others. I would posit that any change towards accountability for action-oriented deconstruction of White dominance in nursing relies on explicit anti-racist learning away from the externalization of dominance, and that this learning must occur in White nurse educators and leaders before any changes further downstream can be expected. This will require that White nurses disengage from systems of White privilege and hold themselves

accountable, over anyone else, to unlearn internalized superiority and align their relational and educational practices with a critical emancipatory praxis (Walter, 2017). This will also require that administrative and educational leadership take ownership of their role in creating progressive action-oriented initiatives that decolonize nursing education and hold educators accountable for their competency. We simply cannot continue to superficially educate tomorrow's nurses while avoiding responsibility for the transformations we need to make.

2.3 Literature review addendum

The literature review that acts as foundation to this study and my discursive trajectory was completed in January 2020. There has been a marked increase in nursing literature with an explicit focus on racism and anti-racism recently, so here I provide a brief overview of literature published between 2020 and 2023. I reviewed a further 43 nursing articles, albeit more cursorily, predominantly from the United States, but also from Canada, Australia, the United Kingdom, and New Zealand. The articles all had a focus on the academic setting of nursing whether that was on educational programming specifically, or scholarship, research, or theoretical foundations of nursing more broadly. I find the prevalence of editorials (30%) in this body of literature (my own inclusive) indicative of a structural thrust towards publishing anti-racist literature. The nurse leaders who occupy the seats of journal editorial boards, most of whom are white, are gatekeepers of sanctioned nursing knowledge. It is likely too early to assess whether the uptake of anti-racist sentiment in editorial form is a result of a genuine anti-racist turn, or a manifestation of social desirability. Where I have learned that journal editors were a major contributing factor to the absence of critical anti-racist nursing scholarship in years gone by, I now understand that a future waning of published anti-racist nursing scholarship may not accurately represent waning interest in nurses themselves but perhaps that anti-racism has ceased to be *en vogue*.

The purposes of this body of literature stretched across identifying applicable components of anti-racist pedagogy, advocating for anti-racist structural action, calls to action along various specific channels, studies which evidenced racism, and a handful of white authors publishing their role-modelling of reflexivity. Carter and Phillips (2021) advocate for the social determinants of health to be thoroughly integrated across curricula, Iheduru-Anderson and Wahl

(2022) advocate for the use of critical language, Altman et al. (2020) recommend integrating analysis of positionality in case studies, Kidd et al. (2022) demonstrate how they used practice-based vignettes to help nurses identify racism and generate interventions, and both Lamberson et al. (2021) and Oozageer Gunowa et al. (2021) report on studies that (again) demonstrate the racist normativity of Whiteness in nursing education. Murray and Noone (2022) have identified structural barriers to the recruitment and retention of 'minoritized' students which include faculty resistance to holistic admissions, experiences of discrimination, a lack of inclusive, anti-discriminatory pedagogical skills, a lack of accountability in accreditation processes, and an unjustified valuing of NCLEX pass-rates as an educational program quality measure. In terms of structural action Nardi et al. (2020) offer five recommendations for nursing leadership to contribute to the diversification (away from white dominance) of nurses which include lifelong critical reflection and learning, formal support through difficult collegial and educational conversations, and liberatory pedagogies. Cooke et al. (2022) contribute counter-hegemonic scholarship that privileges Black kitchen table epistemology and methodology and in which they identify epistemic exclusion of Black knowledge in nursing, which in turn marginalizes health equity knowledge development. They offer ten research principles for developing health equity knowledge which include intersectional epistemologies and critically contextualizing demographic data in research. Lim et al. (2022) provide critical analysis of enduring institutional discrimination and racism in well-meaning nursing research. Students are engaged as valid knowers who can contribute to anti-racist knowledge and action-plans in studies by Mayoum et al. (2022), Waddell-Henowitch et al. (2022), and Lapum et al. (2022). Iradukunda (2023) offers steps for decolonizing nursing to move beyond empty calls to decolonizing action.

Predominant among the calls to action was literature imploring nurse educators to employ and engage personally in anti-racist pedagogy (Iheduru-Anderson & Waite, 2022; Koschmann et al., 2020; Ochs, 2023; Reed et al., 2022; Waddell-Henowitch et al., 2022; Waite & Nardi, 2021). Beyond those were calls for personal accountability in anti-racism (Bell & Daalen-Smith, 2021; Thorne, 2022; Waite & Nardi, 2021), for the application of intersectionality to dismantle stigma (Jaiswal & Mumba, 2022), for Indigenization, decolonization, and reconciliation in American nursing education (Barton & Kahn-John, 2023), and to eliminate Black hair racism (Cox et al., 2021). Literature that critically deconstructs nursing practice and environments to make mechanisms of racism visible are also represented in this recent publication wave (Beagan et al., 2022; Canty et al., 2023; Hantke et al., 2022; Jefferies, 2022; Louie-Poon et al., 2022; Tuffour, 2022).

These last few pages may be pedantic, but I have included such detail to demonstrate that the most recent anti-racist nursing scholarship has gotten exponentially more specific in its identification of sites of enduring racism and offers more breadth in its strategic offerings for radical change (radical as in, getting at the roots of something (Dillard-Wright, 2021)). This is good news. Even if its couched in the reality of tenuous publishing permission via editorial gatekeeping. What is apparent to me, is that we (the Royal we of nurse-writers) have now thoroughly flogged the culturalist nursing approaches to difference and to caring across difference. We have also well-introduced the concepts of racism, systemic and institutional racism, white supremacy and white dominance, and implicit bias. There remains sparse literature that thoroughly voices nurse educators beyond the authors themselves.

Chapter 3 – "We'd really love to but we're just really busy": Silence, precarity and resistance as structural barriers to anti-racism in Canadian nursing education

Permissions

Conditionally accepted for publication in the *Journal of Advanced Nursing*. This included version is the original submitted version.

Abstract

Aim: To identify structural barriers to the uptake and practice of anti-racism in nursing education, specifically in the Canadian context

Design: A deconstructive, critical, qualitative inquiry informed by critical race theory, critical whiteness, feminism, and post-colonialism

Methods: This study employed anonymous online open-ended questionnaire and online focus groups with Canadian nurse educators. The data was analyzed through a contextualist thematic analysis that accounts for data as essential experience and also a product of discourse.

Results: Structural barriers identified are organized into themes of: the academic environment; position and power; racism; program delivery; and Whiteness. Pervasive silence, especially white silence, can be interpreted in related contexts of precarity, self-interest, and institutional violence. Overarching processes of precarity and resistance exert power over the environment of nursing education which act to destabilize, disrupt, and discourage anti-racist efforts and education.

Conclusion: The sustainability of anti-racism should be a primary focus. This entails attending to structures in nursing and higher education that make nursing education precarious work, especially for educators racialized as Other in the white supremacist racial binary of white: non-white. Explicit and ongoing attention to conditions that silence is necessary for any progress to be made. Strategies of applying anti-racism need to be as complex as the barriers.

Implications: Many schools of nursing are engaged in attempts to include anti-racism as learning and environment. The structural barriers that interfere with effective integration of anti-racism as a lens for nursing education must be named and addressed so educators and schools can be successful. The implication of trying to incorporate anti-racism without addressing the barriers is

a very superficial or pocketed application of anti-racism, and a continuation of the status quo that reproduces Whiteness and excludes and harms people racialized otherwise.

Impact: The study addressed both strategies and barriers to anti-racism in nursing education. This paper addressed structural barriers in anti-racism in Canadian nursing education. The main findings are that processes of precarity specific to nursing education in institutions of higher learning, and resistance through Whiteness, decision-making hierarchy, and regulatory structures interfere with the application of anti-racism. This research impacts nurse educators in all nursing schools and leaders in higher education. It also impacts all current and future nursing students as the recipients of the education we provide.

Reporting Method: The paper adheres to COREQ checklist. (Tong et al., 2007) No patient or public contribution.

Keywords: Anti-racism, Racism, Nursing Education, Canada, Higher education, Whiteness, Job precarity, Qualitative research, Critical inquiry, Nursing regulation

Contribution to global clinical community:

- Cultural and educational changes such as operationalizing anti-racism must include analysis and targeted efforts to dismantle the structural barriers that hold up the work
- Job precarity is a major barrier to disruptive work such as anti-racism
- Planning for anti-racism initiatives should include strategies for the sustainability of the work

"We'd really love to but we're just really busy": Silence, precarity and resistance as structural barriers to anti-racism in Canadian nursing education

Introduction & Background

Canadian nursing education has been under clear direction to include anti-racism in the education of nursing students since 2015, when the Truth and Reconciliation Commission's final report was released. The Truth and Reconciliation Commission manifested out of a class-action settlement regarding Indian Residential Schools, the colonial mechanism of genocide that was imposed on Indigenous peoples in Canada for 150 years, starting in 1831 (National Centre for Truth and Reconciliation, 2020). Canada also signed into law, in 2021, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) which identifies a lack of provision of and access to safe and effective healthcare for Indigenous people. Anti-racist nursing education however, has not been broadly applied, despite its perpetual relevance. The current moving racism and anti-racism to the fore in nursing means that Canadian nursing schools must now respond to heightened public expectation, largely as a result of how undeniable the 2020 Black Lives Matters protests made racialized violence, new accreditation standards (Canadian Association of Schools of Nursing, 2020b), new practice standards (British Columbia College of Nurses and Midwives, 2023), and law (UNDRIP) all of which mandates the inclusion of anti-racism, human rights, and the history of Indigenous peoples in Canada and their colonization. The year 2020 is also a marker for the cultural wave both nationally and internationally that, fairly suddenly, made it socially and politically inappropriate to *not* have a (usually outward facing) declaration or statement of anti-racism to represent any or all organizations. Not all anti-racist efforts are equal however, and the saying of anti-racism is not the doing of anti-racism. Are

Canadian nurse educators able to actualize anti-racism in a way that subverts white supremacy and protects the human rights of present and future nurses and patients?

This manuscript reports the primary analysis of a subsection of data from my doctoral study into how Canadian nurse educators take up anti-racism, and barriers they experience in doing so. I come at this research through my experience of being a nurse educator with unacknowledged and unexamined privilege, a lack of racial literacy, and a typically ignorant white Canadian settler understanding of how colonialism shapes everything, in perpetuity. I know that the presentation of anti-oppressive curricula for me to teach my students did not make me competent to do so. At the risk of invoking solipsism, I situate this study as a practice of accountability. A validation[1] for the need for this study then, comes from within; from understanding how this lack of knowledge, skill, and character development harms others and reproduces privilege through my education of and interaction with others. More importantly, from knowing I am not alone in these patterns of ignorance.

My journey towards racial literacy (as an ongoing, non-linear process) began with explicit and longitudinal anti-racist education that I sought and received outside of the nursing discipline, exposure to lived experience outside of my own, and a personal investment of time. These processes are not embedded in the structure of higher education for educators, and the evidence of racial ignorance in nursing spaces (Beagan et al., 2022; Browne, 2005; Eaker, 2021; Hantke et al., 2022), tensions between the theoretical and lived values of nursing (Bell, 2021a; Collier-Sewell et al., 2023; Rabelais, 2022; Valderama-Wallace & Apesoa-Varano, 2019) and

[1] I resist the practice of validating my research inquiry by proving to readers that racism really exists in nursing, and really does impact people day in and day out. This practice centres whiteness and its ignorance or denial of racism, and is dehumanizing.

institutional racism in higher education (Henry & Tator, 2009; Rodriguez & Kokka, 2021) foretells of difficulties in applying anti-racism to nursing education.

The Study

Considering that nursing is dominated by Whiteness[2] (Bell, 2021b; Harding, 2021; Iheduru-Anderson, 2020)) and other hegemonies, and that many nurse educators did not have a critical anti-oppressive nursing education, I asked the following questions through my research: *How do Canadian nurse educators engage in anti-racism in their work? What are the structural or discursive barriers to this urgent work?* The purpose of this study was to better understand the landscape of anti-racism in Canadian nursing education in order to address its strengths and failings, rejecting the notion that adding statements, content, or competencies, on their own, will do the work of personal, social, and institutional transformation. The study also sought to unabashedly identify and name the barriers educators are encountering in self, other, and environment without invoking personal or professional protectionism.

Paper parameters

This paper in particular digs into the data that coalesced around structural barriers to implementing anti-racism in Canadian nursing education. Analyses of the pedagogical and discursive subsections of data are written up in separate manuscripts. That being said, my delineation of these three categories, structural, pedagogical, and discursive, is not meant to imply that they are fully discrete experiences or manifestations. I have defined 'structural' as that which involves the institutional environment, the hierarchy of race, policy, law, formal leadership, money, and the regulation of nursing and nursing education. The strategies and

[2] I have wavered in my previous writing whether to capitalize white or not, sometimes with the trend and sometimes, it seems, against it. I follow now Dr. Leny Strobel (2004) who nods to Mills' (2014, first published in 1997) application of (w)hite on a person, and (W)hiteness as a political and economic world.

barriers described in these categories are often composite threads that resist and weave through conceptualizations of distinctness.

Methods and Procedures

Methodology

My study exists in the qualitative research paradigm as a deconstructive critical inquiry. As such, this study is grounded in social constructionism; that understandings of lived realities, of self, and of other, are developed socially rather than individually, or biologically (Burr, 2015). My study focuses on the work of undoing social constructions of hierarchical human value along lines of what is known as 'race', and the embeddedness of this false hierarchy in societal structures. Critical social theories such as critical race theory and critical whiteness studies are deconstructive in nature, and from various standpoints dissect how power over is constructed and maintained in social systems. Foundational knowledge critical race theory contributes is that race categories are fluid social constructions that are intentionally employed as a value system that benefits those in the white group materially and psychologically in a systematic, ordinary, and everyday manner. Further, it contends that counter-narratives are necessary to make institutionalized white supremacy and privilege visible to those who are blinded by its benefits; that lived experience of negative racialization develops critical knowledge not represented in dominant discourse (Delgado & Stefancic, 2001) and so I prioritize participant voice in this write-up. From critical whiteness studies, I refer to Whiteness as the manifestations and operationalizations of white supremacy such as socialized normalcy, innocence, entitlement to privilege, and violence. As Lea and Helfand say, "whiteness, embodied and institutionalized, has a way of suffocating and diverting attempts to create more egalitarian, socially just cultural, socioeconomic, and political arrangements" (2007, p. 19).

A deconstructive approach seeks to understand why structures of thought and language are developed, what is upheld, represented, or devalued in the process (Gough, 2008). Deconstructivism via Jacques Derrida, rejects binary thinking, that something is either this or that and appraises the world as full of possible meanings, embracing complexity as natural. A deconstructive approach destabilizes binary concepts by demonstrating the hegemony inherent within (Houle, 2009). Sara Ahmed's (2018) theorization on mechanisms of silencing and exclusion based on complaints is applied as a deconstructive framework on silence in this manuscript. Finding language coherent with a deconstructive approach to represent races is a challenge. Racism in a system of white supremacy is predicated on a white/not-white binary, despite both politically constructed categories of humans encompassing multiple and significant spectrums of difference among them. I elect to use language that keeps this diminutive racializing binary visible so as not to silently reify white and not-white, which means that people racialized as white in the white supremacist binary will have the acronym **RWB**, people racialized as Other will have the acronym **ROB**, and people who identify as white-passing will have **WPB**.

Lastly, feminist standpoint theory takes the position that knowledges from marginalized structural positions offer less adherence to hegemonic ideologies that sustain structural injustice (Houle, 2009) and so contribute analysis that is unavailable to people in dominant structural positions. This study in design and analysis is unavoidably a product of my reading of the world. I am a white-racialized person[3], registered nurse, and nurse educator who exists in enough structural positions of privilege that I have experienced very little resistance or harm from the

[3] I come from English, Irish, Scottish and Greek settlers and was raised on the ancestral lands of the Niitsitapi. I now reside on the ancestral lands of the W̱SÁNEĆ and lək̓ʷəŋən Coast Salish people on land that was violently cleared and claimed in the name of white supremacist religious imperialism.

world generally, and have never experienced racism. I intend to avoid centering whiteness in a way that distracts from the harm it causes (as described in Matias & Boucher, 2021), but instead center it when necessary in order to deconstruct it. Also, my experiences in nursing education are predominantly as a sessional or contractual educator, so I am more attuned to that sphere than I am to the long-haul of tenure and its accompanying requirements of service.

Study design

Participant safety and an anti-colonial resistance of hegemonic binaries guided the design of the study. I have critiqued elsewhere an absence of racial identity analysis in nursing research that purports to be about racism, arguing that it misses the foundational unit of interest (Bell, 2021b). I designed the study to collect demographic data about salient participant identities that would allow this angle of analysis. However, as Beagan et al. (2022) found, it remains necessary to report this demographic data with much less specificity than I hoped, as the protection of my participant's anonymity outweighs all other research interest. A more robust analysis of identity is taken up in a separate manuscript focused on discourse, and not here.

Participants were registered nurses currently working in Canadian Association of Schools of Nursing (CASN) accredited programs. I used non-probability, convenience sampling. Participants were recruited via publicly available contact information for nursing faculty on institutional websites, of which I found approximately 3500. Some entire schools were excluded based on the unavailability of public faculty contact information, and other schools were excluded because their nursing faculty were listed among larger health departments that made identifying the nursing faculty far too labour intensive. I compiled contact details by province and territory, randomized the order of names within, and recruited a proportionate number of people per province in waves of recruitment until I exhausted the lists. Participants received an

email from me with the study invitation along with a letter of information and a link to an online questionnaire. Snowball sampling was encouraged in the email invitation, with further participants establishing their eligibility. Consent in the questionnaire phase of the study was implied by their completion of the questionnaire, and was collected as written consent for the focus groups. This study was approved by the University of Victoria Human Research Ethics Board, protocol #20-0548.

As described above, a major design priority for me was to enable people who are identifiable by their how they are racialized, or by otherwise marginalized and underrepresented personal or structural identities in nursing, to participate without recourse or concern for providing counter-hegemonic data. This meant sampling widely geographically, rather than a discrete location, and both creating anonymity in the data and an option for distance from myself as a **RWB** researcher.

Interested participants self-selected for focus group participation by following an external link to provide their contact information in a way that kept their questionnaire data anonymous. Focus group participants received a second information letter with a written consent form.

Data collection

The online anonymous questionnaire had 14 questions, seven of which collected demographic data. The questions were developed to answer my research questions, and in response to my literature analysis (Bell, 2021b) and theoretical framework. The questionnaire asked how educators address racism through curricular content and pedagogy, and what barriers, if any, prevented or interfered with this work. The questionnaire, recruitment email, and information letter were translated into French so this phase of the study could be offered in both official Canadian languages. Focus groups were used to expand on the data received through the

questionnaires. It was important to me to engage in a relational data collection method that could situate the knowledge socially, better than a disembodied questionnaire. The two methods worked together to gather contextual, situated knowledge, alongside individual knowledge unmediated by social interaction.

These methods resulted in 94 completed questionnaires, from which I drew 17 focus group participants. Six online focus groups were run, each lasting between one and two and a half hours. Two of the six focus groups were run in racial caucuses, as elected by the participants; a white group and a BIPOC group[4]. Participants engaged in lively discussions that were minimally directed by me. Focus groups were only offered in English because my French language skills are basic. Data collection ran from April to June, 2021. Focus groups were recorded and transcribed verbatim.

Data analysis

After data cleaning, the transcribed focus group files and questionnaire data were moved into NVivo, a qualitative data analysis software, for coding processes. Analysis centered on contextualist thematic analysis, which sits between realism, reporting on the experiences of participants, and constructionism, which reports how the experiences of participants are effects of discourse (Braun & Clarke, 2006). I followed the phases of thematic analysis as described by Lester et al. (2020), including the three stages of coding which moves abductively, meaning it moves between inductive and deductive approaches, moving from theory to data and back again (Graneheim et al., 2017). Transcripts and questionnaire data were read through in entirety, with initial reflections recorded in memos. This followed with inductive coding of the focus group data. The research questions and central questionnaire questions were then applied as deductive

[4] I asked participants if and how they wanted to form caucus groups, so the term BIPOC came from the participants.

upper level code categories. Eventually I inductively developed themes of structural, pedagogical, and discursive approaches and barriers, which were in turn applied as deductive categories to further organize the data. Questionnaire data were coded within and beyond these upper level categories and then the two data subsets were combined. This iterative process continued until the categories and themes were stable.

Findings

Following in tables 1 and 2 are demographics of my research participants. I combined some geographic areas when the number of potential participants found through recruitment was low enough to risk someone being identified by their responses. As demonstrated in table 2 the concept of race identity is nebulous among these nurse educators. I have listed only the identifiers and not the numbers of participants to maintain an analytic focus at the discourse level. That being said, it bears noting that when the many categories that could mean white are combined, it comprises 66% of the participants. As mentioned, the data were separated into categories of barriers to anti-racism and strategies of anti-racism. The upper-level themes I developed under the frame of structural barriers that are reported below are: the academic environment; position and power; racism; program delivery; and Whiteness.

Table 1 Participant demographics

Characteristic	**N (percentage)**	
	Questionnaire	Focus groups
Total participants	90	17
Gender		
women	77 (85%)	14 (82%)
men	12 (13%)	3 (18%)
non-binary & genderqueer	1 (1%)	0

Geographic area[5]		% of national population
Alberta	5 (5%)	12%
British Columbia & NWT	19 (21%)	14%
Manitoba & Saskatchewan	12 (13%)	7%
Ontario	36 (40%)	39%
Quebec	11 (12%)	23%
Maritime Provinces	7 (8%)	6%
Doctorate degree	59 (66%)	15 (88%)
Time in practice		
< 10 years teaching	31 (34%)	6 (35%)
> /= 10 years teaching	59 (66%)	11 (65%)
Tenured	38 (42%)	8 (47%)

Table 2 Racial identifiers claimed by participants

Human	Settler Euro-Canadian	Middle Eastern
Métis	African	Caucasian
Black	African Canadian	Mixed race
Black Canadian	Non white	Jewish
White	Asian	East Indian
White European	S Asian	Irish/English
White anglo saxon	SE Asian	White presenting
Quebecois blanc/he	White settler	“I don’t”
Hispanic	Mi’kmaq	

[5] There were no CASN accredited schools in the Yukon or Nunavut to recruit from. Population statistics from Stats Canada (2023).

Structural Barriers

Academic Environment

Structural issues in the academic environment brought up by my participants center around job precarity and structures that support the status quo. Related to the expectations of academic output, a lack of time to adequately address racism or incorporate anti-racism was a concern for many participants. Some described a lack of time to develop content, to collaborate with other faculty, or to develop their own skills. Several participants drew attention specifically to the workload of part-time or sessional lecturers[6] who are often given pre-developed courses to teach with very little time to familiarize themselves with the content; they lack both autonomy and agency over the material alongside inadequate prep time:

RWB: *"If you're a part-time lecturer, you may be managing several courses at a time, where you just don't have time. And you're just trying to get those tick boxes checked off and you're really just trying to survive. And so meaningfully engaging and how you would have practiced and taught could probably have looked very different..."*

Others contextualized the lack of time as a result of unrealistic workloads for full-time faculty working towards tenure that include required departmental service and career-building projects: ROB: *"I used to describe the pre-tenure experience as kind of like an out of body experience. And it's like you can never give enough time, you can never give enough of yourself."* Participants discussed the annual reports that document their output as evidence for promotion up the ladder toward tenure. The work that is required to be done, whether that means specific projects or collaboration with recognized or powerful people, is often exclusive to the anti-racist work the participants already do, or wish they had time to do:

[6] The terms used for various levels of teaching positions varies across the country

RWB: *"From my interactions with faculty contract lectures, everyone's really well intentioned, and I think people do want to but I think part of it is the structure of academia, … And I think in combination with that maybe lack of urgency, you do prioritize things that are going to show up on your annual report."*

So not only do they have at-times unrelated work they must do to continue progressing towards tenure, but there is work they are doing that cannot be included on the annual report because it is not considered of value for promotion.

Beyond the part-time to full-time dichotomy, since many nursing programs in Canada are collaboratively run between colleges and universities, the workload of university professors was also contrasted with college professors. University faculty may have a research and scholarship component to their job structure, which protects time to engage in research, course design, and maintaining currency with new literature. A college professor however, teaching *"five, six courses a term is not going to have that luxury".*

Participants raised the concerns they have for themselves and others either in pre-tenure or as a contracted instructor about their job precarity. Participants report feeling unsafe to be the one who challenges the status quo, or to have what is seen as vulnerable or risky conversations about racism with their students, because they feel it risks their chances of staying employed.

RWB: *So for me, I've been part of the school for 20 years now and I do feel safe in my job. So I absolutely feel safe in being the person who raises the questions and pushes for conversation. But I know some of my colleagues …don't feel that they can be the people to bring something up because they feel that they're too much at risk, which I think is just another way of silencing people, right?*

Another significant finding about the academic environment is that many participants see equity, diversity, and inclusion (EDI), broadly, and anti-racism specifically being addressed in only perfunctory or symbolic ways. Terms such as *"lip service"* and *"small level change"* are used by participants to describe the level of engagement they see in their nursing departments. Symbolic EDI can be seen in how schools employ *"ritualistic type of readings"* to give respect to *"the land",* or work to *"acknowledge our history of violence, but not the ongoing day-to-day violence that continues to happen".* These participants describe a veneer of commitment to anti-racism, but a lack of material support and resistance to change as the reality.

Position and Power

Some participants shed light on the experience of powerlessness even in positions such as directorship, tenured professorship, and vice or assistant-dean. They reflect on the hierarchical nature of power in academia, noting that in order to effect change both they and their students feel they have to circumvent due process and go straight to the highest level of authority they can reach. This powerlessness is at times represented as result of the rigidity of nursing curriculum and at other times a result of faculty not being seen as a stakeholder by university leadership. Further, the powerlessness is compounded by living in and with marginalized identities. "Oftentimes, the only power and authority that I actually have is the wisdom to know that sometimes the only people who can actually really affect change is to work with the students" (RWB).

In a deliberate narrative flip I gathered data that describe issues that arise from having too many white people in the faculty. These include lacking Indigenous and Black[7] scholars, the scholarship they would produce, and the leadership they may want to offer in decentering

[7] These are the two peoples named in this section of data. It is not an analytic exclusion of all other scholars who identify differently, but it does reflect an exclusion of consideration in the data.

Whiteness in theory and practice. An inability to *"purposefully indigenise [programs] because we felt there was not yet enough people around the table to collaborate"* with. A lack of students "*of colour"* in graduate programs and undergraduate students not *"seeing themselves in the faculty".* And epistemic hegemony through RWB people in leadership positions, on advisory committees, on research award committees, and faculty research projects aimed to address racism.

RWB: *We just don't have a lot of BIPOC profs, they're already overworked and so on. So now it's the question of we're creating something that is again White, you know, it's evidence-based in the sense that we're going to the literature to inform our practice, but it's still White-led.*

Other participant, ROB: *Yeah, and it's White research*

Alongside an overabundance of RWB people is their active resistance. Participants articulate the challenges they have faced within the faculty, in faculty meetings, in their inboxes, and with the formal leadership. Some participants name a dismissiveness amongst white faculty when their students draw attention to racist and white-centric content or practices. Others speak of denial strategies, a lack of will, and prejudice.

RWB: *[Some people] in my Faculty think EDI is nonsense. We have an almost all white, hetero, able bodied faculty staff. Not one Black professor. I raised issues when a colleague made an ill-advised comment, and I was told after the meeting to watch my tone. They are the biggest barrier.*

Racism

The examples and manifestations of racism accounted by the participants are broad. The main sub-themes I developed are experiences of racism, fears of reprisal, and the burden of extra emotional and material labour. There are also micro-themes that were not extensively articulated,

of white supremacist material, unsafe accountability structures, and internalized racism. Examples of experiences of racism are a devaluing of anti-oppressive and anti-racist research, as compared to post-positivist research, students judging anti-racism from a Black professor as self-interest, and significant white faculty push back when anti-racism research is actually funded and carried out. So the racism experienced is both institutional and interpersonal from students, *"students are disrespectful to skin colour, tone of voice, physical appearance, and language"* (ROB), and faculty alike,

ROB: *Racist faculty members are a big barrier. And there are a lot of them. Anti-racism is not viewed as a priority and when BIPOC faculty try to address it, the white folk try to take it over as they "know best".*

The environment of nursing education is experienced as unsafe in that many participants across racial identities report a fear of reprisal for speaking up, standing out, or challenging the status quo; though this experience was concentrated in ROB participant's experiences and in anecdotes about students.

"As a woman of colour, I would be fearful of saying and speaking my mind, and a woman that's Caucasian would be fearful of siding with someone of colour or siding with that idea to be supportive of somebody of a different race, cultural creed".

Another ROB participant: "*And so I just sit back because these -- I've experienced incredible violence and it doesn't matter."* Some participants spoke of unsafe and ineffectual complaint processes or feedback forums for students, and of the power differential students have to overcome to make a complaint regarding racism about an instructor at all.

By far the densest sub-theme is the burden of emotional and material labour experienced by faculty with devalued racial identities in this system of white supremacy. Too many RWB

people in faculties creates additional pressure on the fewer ROB faculty to take on anti-racism work in multiple facets, often without recognition of the work in terms of contributing towards promotion. Informal labour that arises is in relationship building and providing support for students that are affected by racism or the Whiteness of nursing education. Participants also describe an exhaustion not only from the increased demands on their time, but also as an ongoing state from having to mitigate daily microaggressions, a constant filtering of language and demeanour, and the consideration of how and when to do so. The meeting of these two conditions creates a need for ROB faculty to step away, for self-preservation. A participant explains how even that comes at a cost of burden knowing if they walk away, the work may not get done, or may not get done appropriately:

ROB: *And you feel a bit like you're caught in a place where you can't win, because you either step away and say no to all these things, which are really important to you, because you know they're going to affect the next generation of people coming in…or you watch it unfold. As you would expect, a lot of the times, with limited views, with limited engagement, even the most well-meaning people, and that burden is real.*

Program delivery

Program delivery operates more as a location than a theme but the main features of this data are curricular inflexibility, inaction broadly, and the spread of education across contractual instructors, colleges, and universities. Participants find the curriculum to be rigidly constrained by an enormous amount of required content that is imposed through regulatory and accreditation processes. *"But the question of overburdening a program to the point where you can never really build on something and always be in a constant flux of internal reflection and evaluation and report generation is problematic in and of itself."* The entry-to-practice competencies alongside

a hyper focus on the national licensing exam (the NCLEX) often reduces any added anti-racism learning to tokenistic representation.

RWB: *I think as a profession, we have put ourselves in a place where we're not necessarily able to even be effective in how we can bring about the types of changes that I think need to occur for us to be in a good place to continue and to grow as a profession.*

2nd participant RWB*: And the NCLEX reinforces that.*

3rd participant ROB*: Oh, yeah.*

1st participant*: Yeah.*

Further, consistent application of anti-racism in content or practice to all levels and sites of educators is a very complex task. Participants speak of inter-institution dynamics that involve power gradients between colleges and universities, varying educational preparation of educators, and course familiarity. Last-minute and contractual hiring of clinical instructors from the field excludes them from ongoing conversations at the faculty level.

RWB: *And as a part timer, I mean, you're working full-time at the hospital and some of us are doing graduate studies. There's no connection to the school. You sort of just say, okay, Thursday, Friday, I teach on this unit at the hospital, and then you get a pay check. So to ingrain this culture change at that sort of precarious work level is really challenging.*

Lastly, at the site of program delivery, is inaction. Inaction is manifested through faculty saying they don't teach anti-racism, either because they aren't prepared to do so, or because it is seen as irrelevant to the courses they teach: *"I would mention racism in passing if and when something warrants it but I teach mostly methods and there aren't that many opportunities."* Inaction also manifests through a lack of teaching and learning resources for anti-racist pedagogy; some participants say they would like to engage with anti-racist pedagogy, but aren't

supported at the institutional level to do so. Finally, many participants cite competing priorities such as accreditation processes, discrete topics of interest in nursing, staving off burnout, a sole focus on Indigenization[8], and Francophone-Anglophone intra-faculty dynamics.

Whiteness

Whiteness is named as a distinct barrier through deflection of racial privilege: ROB *"Right. But when you teach, whose voice is the strongest?"* RWB: *"That's the point, the books are the strongest. It depends on where you're coming from."*

A distinct barrier through delegitimizing non-white voices: *"and I feel that if I wasn't White saying the exact same things that I am, I would be less safe."*

A distinct barrier through demonstrations of in-group behaviour:

WPB: *So I think there's these moments where I also really recognize that in their taking me as somebody who is like them, they will say these things, they'll share these moments. I do use that sometimes to my advantage to continue a conversation. And I think that can sometimes be good and bad.*

Through silence:

RWB: *"and I think that there's a lot of silence, as you said, absolutely. That when you point something out as being problematic, there's a lot of silence and you can sense the discomfort but people aren't willing to say yes, you're right. We need to do this. And it's afterwards I find that I'll have somebody come and say, 'I was so glad that you raised that at the meeting because I was feeling the same way' but not feeling that they could speak."*

And through a privileging of white comfort:

[8] Indigenization doesn't mean the same thing to me as Indigenous-specific anti-racism, but this is how it is represented in the data. These topics are explored more fully in another manuscript.

RWB: *The structural [barriers] are more challenging and mostly the results of my faculty colleagues who are in a different space then I am. When I have brought it into conversations, there are barriers put up. For example, discussions about need to create "safe spaces" for faculty to talk (we are all white, cisgender), or lack of willingness to address our policies and practices - and I commit sacrilege by challenging Nightingale being put on a pedestal.*

White fragility and the weaponization of it are evident in the data in examples given by participants and in some participant responses themselves. There are examples given of educators shutting down when challenged about racism in their teaching and not being willing or able to engage with students. There are examples of participants saying they have attempted to engage in anti-racist education, but have stopped because of negative reactions, or perceived student sensitivity. And examples of participants centering how hard it is for them to teach anti-racism as RWB people, some of these statements accompanied with reflexivity on the matter, and some without. Lastly, a weaponized white fragility is evident by participants feeling they have to walk *"on eggshells"* or *"around the elephant in the room"*, or avoid discussions of white overrepresentation at all, knowing how intense the white reaction is.

Discussion

As a non-expert researcher, my journey of sense-making of the data often leads to more questions as well as discrete theorized answers. Is time to stay current in your field and thoroughly consider your course design a luxury? Or is it the lowest bar for quality education? If it's a luxury reserved for the top of pyramid, then is the rest of nursing education just a machine of rote competencies?

Are faculty really powerless in those positions of power? Can professors not individually affect curriculum at all? Are they deflecting responsibility or not? I know that in the past when I

gestured to the position two rungs up the ladder from me, and handed the student with a complaint the appropriate contact information, that it likely felt like deflection and even dismissal. Some participants shared that they often consider subversion of authority and curriculum their only path forward. Subversion as structural strategy is taken up in a separate manuscript focused on strategies.

On time[9]

Participants claiming that time is a major constraint certainly can be seen as a feeble excuse for not addressing racism. I do want to frame this data as coming from educators who are arguably quite invested in anti-racism, some of them due to their own experiences of it. Since my study used convenience sampling all of my participants from 3500 recruitees self-selected. An assumption I make is that the faculty members who took the time to read my cold-call email, follow the link, fill out the questionnaire, and the further 17 that gave me a couple of hours of their time, at times while kids were being put to bed, at times on a Saturday morning, at times during their work day, are a sample of some of the people most interested in the application of anti-racism in nursing education. My long-winded point is that even they are finding that time, in the structure of nursing education, is a significant barrier. So, I see this *as both* an essential experience and a symbolic device that exempts people from acknowledging it is not a priority.

On Silence

How many of the structural barriers my participants experience lead to silence? I did have a 'silence' code at one point in my analysis, but I eventually moved to deconstruct it as an end result of other processes. The question why? is perhaps more constructive towards replacing white silence that is complicit with racism with responsibility, accountability, voice, and action.

[9] I borrow this stylistic play on content and heading from Sara Ahmed

Beagan et al. (2022) in their recent work focus on silence as a lived cultural expression of white supremacy and Iheduru-Anderson and Wahl (2022) on silence as absent discourse resulting from a-racial or post-racial nursing discourses. Beagan et al. (2022) note that silence can be protective, differently, but for both ROB and RWB people. I lean on Sara Ahmed's (2018) brilliance here in deconstructing the mechanisms of institutional violence that create a culture of silence in her work on complaint. I'll lead by clarifying that this argument does not work to dismiss the way white silence is used to protect white interest, but rather how white silence is a manifestation of white privilege being leveraged in an environment of institutional violence.

Ahmed dissects *complaint* in the academic institution, the concept of which I am applying here as any of the desired responses in place of silence. First, that complaint is often reframed as complaining, and complaining as personal tendency. This violence is demonstrated through white educator's frustration at students calling out racism in content and practice. Second, that complaint makes the complainer stand apart from the group, and this exclusion is understood as self-inflicted, since they had to stand apart from the group to make the complaint. This operates in a 'you brought it on yourself' kind of blaming, and likely is more vitriolic the louder or angrier a complaint is perceived to be. Third that complaint is seen as self-interested, rather than prioritizing group interest. A "complaint is treated not only as potential damage but as actual damage" (Ahmed, 2018, p. 23), so speaking up about an injustice becomes seen as damaging to the group interest, where in our context could be nursing professionalism, the public image of nursing, white superiority, etc. When the thing that is not supposed to happen is actually a norm, as racism is, "a use is sustained by a fantasy that a use can be suspended" (Ahmed, 2018, p. 21). We can consider the proclaimed 'zero-tolerance' environment, that Beagan et al. (2022) also critique. Here, the institution must symbolically produce that absence of use, that they have

tolerated nothing, and so it no longer exists. This manifests as silence, or silencing, and denial. So, now that all nursing schools and most public institutions in Canada have belaboured out statements of commitment to stamping out racism with zero-tolerance, have we ironically created environments in which racism can't be spoken (complaints made) lest the speaking of it become the problem, such as in institutions invested in maintaining themselves?

Lastly, of Ahmed's deconstruction of speaking up, they say that even one violent sentence can be sentencing in that "you can stand out by just experiencing violence as violence" (Ahmed, 2018, p. 19) and then not playing along in a way that would invoke "institutional passing" (p. 19). As soon as it is spoken it excludes, as it puts the onus on whoever experienced the violence as violence to decide whether to come apart from the group, in essentially a move of cultural transgression, knowing that the blame for the separating or exclusion tends to lie with the one who speaks, who doesn't laugh protectively, or who doesn't shoe-gaze silently. So silence is protective. "The problem of passing is that if someone fails to pass, those who have passed are still participating in what has left someone stranded" (Ahmed, 2018, p. 19). And silence is privilege. Both in the avoidance of known violence.

And on precarity and resistance, then

It may be apparent that even in my attempt to tease apart my participant's data into feasible and hopefully cohesive categories, elements of many resisted the distinction as they are deeply entwined with others. A fear of reprisal is undeniably connected to both white fragility and job precarity. Hierarchical power structures are embedded features in, and organizing precepts of program delivery across college-university partnerships. The connections go on. Pulling back analytically I can name two conditions, precarity and resistance, that exert power over the field of nursing education and obstruct productive anti-racist pedagogy, practice, and

policy. Precarity is what keeps progressive anti-racist efforts destabilized, unable to root down and become a part of the fabric of social and institutional nursing education. Resistance is what keeps the status quo in its place as institutional and professional structure and culture.

White fragility takes up a lot space, both in absorbing attention and its potential explosiveness. This makes anti-racist work precarious as it is subject to the comfort of RWB people in any given space. Work relationships among inter-institutional faculty members that are grounded in hierarchy make anti-racist work precarious by reducing agency over work and introducing conditions for conflict between the members, especially in terms of different racial positioning. Last minute hiring, and literal precarity of academic work before tenure make anti-racist work precarious in that there isn't a stable enough body of educators to do the work of cultural transformation in. The hierarchical distribution of the "luxury of time" makes anti-racist work precarious in that it may be less developed in the years of nursing education ideologically focused on the fundamentals[10]. Lastly, the toll of the burden ROB faculty members carry is precarity for anti-racist work, because if they don't do it, who will? Who *really* will?

Hierarchical power and decision making in academia creates structures of resistance to change. The tenure promotional process *is* resistance to academic time being focused on anti-racist work. Ineffective complaint processes are gaslighting, and gaslighting is silencing, and silencing is resistance. Racism is silencing and silencing is resistance. And where an institutional and professional culture are violent, silence is the norm.

Recommendations

In an insufferable culture of silence for those held back, harmed, demeaned, exhausted, killed, by racism, a tangible deconstruction of the structures that keep us from speaking racism as

[10] A critique of the conceptualization of nursing fundamentals exists in another manuscript about pedagogical barriers

it happens and where it happens, is a very low bar to set for justice. As a participant in one of Robin DiAngelo's workshops said, being able to speak about racism in white environments without experiencing violence would be revolutionary (*Amanpour & Co: White Fragility*, 2020). If the institutions and structures of nursing education are the bodies, and the silencing, the chaos, and the violence, the immune system for preventing culture and system change, it is the institution that will survive. A high-level recommendation then, is to radically address the structures that maintain precarity and resistance in institutionalized nursing education. Sustainability of anti-racist pedagogy and policy, alongside the sustainable retention, health, and safety of nurse educators racialized against Whiteness should be paramount. While the application of Sara Ahmed's theorization here could never be flawless, an explicit and cultural acknowledgement of these mechanisms at play, at all times, in all social settings could mitigate some of the power it exerts on us. And this, of course, is not a novel suggestion, to address silencing. But one that, as evidenced through the participants of my study, and others, has yet to be authentically applied in nursing spaces. A bolder recommendation, still living in my (and others') imaginary, is that nursing education extricate itself from the university. To decolonize, as in to come out of colonial structures.

Limitations

I acknowledge that in the long period it has taken me to complete my research, I am complicit in what Philip Darbyshire (2022) names "appearing fully committed to doing nothing at all about structural and systemic racism" (p. 1). A significant limitation in my study is the relative absence of Indigenous voice and experience. I had an organizational failure when scheduling the Indigenous-caucused focus group that could not be remedied in the window of time I collected data.

I find satisfaction in the possibility that this data could have different meanings for another research team. Though I embrace the messiness of qualitative research and standpoint inflected deductions I also acknowledge this as a limitation of a white one-person research team with a material deadline.

Conclusion

While this study does not provide sanctioned generalizable data, the educators that wrote and spoke to me about their experiences are spread across the country in many different schools of nursing, at both the college and university level, and from a range of standpoints. Their experiences ring true to me from what I also know experientially from within myself and the academic nursing environments I have been in. The study also echoes and expands on a growing body of scholarship focused on the Canadian nursing educational context. This arm of the study provides insight about significant and complex structural barriers to the uptake and application of anti-racism in Canadian nursing educational contexts, which is imperative in the development of accountability for racial literacy and human rights in Canadian nursing. Our strategies need to be as multi-layered as, and *more* effective than, the barriers we face.

The messiness and interwoven complexity of the location where nursing, white supremacy, higher education, and capitalism meet is daunting, as they all seem inextricable from each other. I can't say the whispers of 'burn it all down and start again' don't have appeal to me, and wouldn't for some of my participants. But I know that even in that version of reality transformation, both macro and micro, won't happen overnight.

Chapter 4: [anti-racism needs to be] Spread not sprinkled: A qualitative analysis of pedagogical applications of anti-racism in Canadian nursing education

Abstract

Background: Anti-racist education is a new priority in nursing schools but remains underdeveloped in nursing scholarship and practice. Anti-racist pedagogy (ARP) is a critical transformative pedagogy that is articulated in interdisciplinary scholarship and needs to be thoroughly applied to nursing education. Nursing education has been identified as a site that prioritizes whiteness in its educators, students, and epistemologies. This means that the people responsible for mobilizing anti-racism as nursing knowledge and into the structures through policy and human resources are majority white and offers rationale for why nursing environments are still so harmful for people racialized as marginal.

Objectives: The study objectives were to understand and map how nurse educators are engaging in anti-racism and what structural, pedagogical, or personal barriers exist that are interfering with this work.

Design: Critical inquiry that applied a contextualist qualitative content analysis. The theoretical underpinnings are social constructionism broadly, and critical race theory, critical whiteness, postcolonial theory, and intersectional feminism specifically. Methods included anonymous online open-ended questionnaire and online focus groups coded and analyzed in NVivo. Participants were nurses who are educators in baccalaureate nursing programs in Canadian schools of nursing in both colleges and universities in ten provinces and one territory. 90 participants completed questionnaires and 17 participants attended focus groups run early in 2021. Reporting satisfies COREQ.

Results: Educators who engage in anti-racism do so by teaching related foundational concepts, articulating how racism and healthcare intersect, and providing counter-narrative that disrupts sanitized Canadian and nursing discourse. Educators apply theory as pedagogical framework, use discussion, case study, and critical analysis as instructional methods, curate or modify educational resources, and attend to the quality of relationship they form with students through attention to language, mechanisms of accountability, and efforts to make their learning environment safe. Some educators are deterred from engaging in anti-racist teaching though due to ignorance and privileged comfort related to whiteness. Educators racialized as marginal can be deterred from engaging in anti-racism because of their hostile work environment. Educators may misunderstand efforts of Indigenization to be anti-racism and others contest the exclusion of anti-racism for non-Indigenous people. Anti-racism is still largely lacking from nursing curricula which leaves individual actors to include it in their courses and only those with developed anti-racist knowledge can do so. Very few study participants communicated a framing of ARP as including both content and process, and the many approaches and content found in the study were spread very thinly across participants rather than existing as structured educational frameworks.

Conclusion: Hierarchical racial constructions are fundamental units of influence on human interactions and health and so should be a pillar of nursing education. Nursing fundamentals could be reconceptualized to be grounded in interdisciplinary political and anti-oppressive knowledge. Nurse educators in all racial standpoints should be able to articulate components of, and apply, anti-racist pedagogy and it should be not sprinkled but spread, edge to edge and all the way through nursing education. Educators need to get clear on the purpose and function of Indigenization and not uncritically conflate it with anti-racism, or co-opt it to couch anti-racism,

especially if anti-racism isn't taken up anywhere else, nor applied to anyone else. Leadership in schools of nursing should address these inconsistencies in conceptualization and in pedagogical application so that valid processes of Indigenization are not co-opted and so that nurses can identify and mitigate racism towards anyone harmed by it.

Keywords (4-8): anti-racist pedagogy, anti-racist framework, nursing education, higher education, Canada, nurse educators, transformative learning, Indigenization, critical social theories

[anti-racism needs to be] Spread not sprinkled: A qualitative analysis of current pedagogical applications of anti-racism in Canadian nursing education

1. INTRODUCTION

In Canada there is mandated anti-racism in healthcare education through the formalization of the 2015 Truth and Reconciliation report (TRC) Calls to Action (National Center for Truth and Reconciliation, 2015), British Columbia's legislation of the Declaration of Rights of Indigenous People Act (DRIPA) (Ministry of Indigenous Relations and Reconciliation, 2019), and specifically in nursing education through new practice standards (British Columbia College of Nurses and Midwives, 2023) and accreditation standards (Canadian Association of Schools of Nursing, 2020b). The time of waiting for direction and commissioning reports to build rationale for action is done; we are in the period of necessary expansive material response. With very little scholarship centering nursing faculty in the practice of educating towards anti-racist environments and nurses, I conducted a critical qualitative study to map and understand how nurse educators in Canada were taking up anti-racism, and to identify the barriers that arise in doing so. This paper reports on the arm of data related to pedagogy; both strategies of anti-racist pedagogy and pedagogical barriers as conceptualized by nurse educators. Beyond the data analyzed here, the broader study is composed of analyses of structural strategies and barriers, discursive barriers, and the salience of nurse educator's claimed identities on their work.

2. BACKGROUND & STUDY CONTEXT

I am a Canadian nurse educator and multi-generational white settler of English, Irish, Scottish, and Greek ancestry. I have been teaching nursing in varying capacities since 2012, all the while inadvertently reproducing elements of my socialization into whiteness, Canadian

colonial culture, and power stratifications in nursing through my interactions with students and people seeking healthcare. The site of nursing education via white educators has since been a focus and interest of mine because I know first-hand how easy it was to maintain my ignorances, my implicit racial biases, and my implicit sense of superiority in the nursing role. The structural moves of cementing anti-racism through regulation and accreditation are necessary, positive, and have been hard-fought, and I am challenging here any desire to rest in the notion that adding statements, isolated content, or competencies on their own will do the work of personal, social, and institutional transformation. Nursing education is mobilized predominantly by white people in predominantly white institutions, and because of the racial privilege of being ignorant into adulthood of how racial oppression operates all around and through us (mainly white folks), I am particularly interested in interrogating how anti-racist nursing education is unfolding.

There has been a bloom of nursing literature on racism in the educational context of late, and a thrust of this literature demonstrates an acute need for examination through the lens of anti-racism of nurse educator's subjectivities and pedagogical practices, and nursing curriculum broadly. Dr. Claire Valderama-Wallace conducted a study with 33 nurse educators about their integration of social justice into their courses and concluded that there are significant differences along 'the color line' whether the education provided resisted or upheld a colonial and white supremacist status quo (Valderama-Wallace & Apesoa-Varano, 2020). Teaching approaches are contrasted with each other with those effecting a social justice education being the ones that advance equity and action, attend to context, and engage in relationalism. Teaching approaches seen to maintain the status quo focused on building awareness and reinforced stereotypes, white Christian centrality, individualism, and notions of equality and tolerance. This delineation is supported by a grounding in critical theories and anti-oppressive pedagogy (Blanchet Garneau et

al., 2018; Freire, 2017; E. A. McGibbon & Etowa, 2009; Mezirow, 1996). Despite a number of mandates and claims of social justice ethics and for anti-racist education, a lack of broad application and formal curricular integration underpins both their study and my own. This is important because it identifies that this education is not a given, and it locates all the responsibility onto individual educators. Key differences in our studies are the specificity of anti-racism as study concept and the geographic location and breadth of my study, which changes the contextual landscape and its complexity. Further my study was conducted in the sociopolitical aftermath of the violent death of Mr. George Floyd (and Atatiana Jefferson and Ahmaud Arbery and Joyce Echaquan and Breonna Taylor and many more) which changed the availability of explicit language around racism and anti-racism in the social sphere.

3. METHODOLOGY

The study was a qualitative deconstructive critical inquiry grounded in critical social theories and social constructionism. Participants were nurse educators from across Canada teaching in universities and colleges accredited by the Canadian Association of Schools of Nursing (CASN) in the preparation of baccalaureate nursing students. They were recruited via an email to their publicly available contact information from institutional websites. As a white cis woman researcher I worked to mitigate the potential risks of harm for my participants with marginalized or oppressed structural identities through any inadvertent reproduction of white supremacy and other normativities on my part, by offering the anonymous questionnaire as a data collection method. This of course, does not change that the entire study is designed by me and thus through the lenses currently available to me. 90 educators completed an anonymous online questionnaire delivered in both French and English, and 17 educators participated in online focus groups, with an option of remaining anonymous to the other participants. Table 3 contains the questionnaire

items relevant to this manuscript. I delineated the *what* from the *how* in the study to get at the differences between the anti-racist topics we teach and the anti-racist methods we employ to do the teaching, since "anti-racist pedagogy is a process that moves beyond simply incorporating racial discussion into classrooms; rather it is about how one teaches" (Kishimoto, 2016 as paraphrased by Garland & Batty, 2021, p. 22). Audio and video recordings of the focus groups were transcribed verbatim and all data were coded and analyzed in NVivo and through iterative writing processes. Abductive analysis allowed me to move between inductive and deductive strategies, developing themes organically from the data and within a framework of the research and questionnaire questions.

Table 3 Items from questionnaire

1. Describe how you engage in anti-racism in terms of *what* you teach?
2. Describe how you engage in anti-racism in terms of *how* you teach?
3. Describe what barriers exist that prevent or interfere with you teaching anti-racism content to your nursing students. Barriers could be personal or structural.

4. RESULTS

Demographic information about location, gender, race and ethnic identities was collected in the questionnaire: 85% of participants were women, 13% were men, and 1% was non-binary. Though the concept of race itself as a descriptor for identity is potentially offensive, by asking participants to name their own racial identifier I avoided the harmful application of diminutive racist categories. The corresponding data demonstrates that participants conceive of themselves

as racialized in many ways beyond the white:non-white binary. It also provided opportunity for participants to subvert the application of racial identity to themselves, which 6% of the participants explicitly did, though their reasons for doing so cannot be interpreted. Table 4 shows how the participants identified themselves racially. Beyond the demographics of the participants, and nurse educators broadly, the racial identities of student groups add to the range of contexts the participants are working in; some work with predominantly white students and other with predominantly immigrant students and students that are racialized as marginal. Knowing that we bring our full humanity to our teaching work, despite hegemonic notions of professionalism that fantasize that we can check pieces of ourselves 'at the door', these features of our educational environments are significant in the mobilization of anti-racist pedagogy.

Table 4 Racial Identifiers

32% of participants	62% of participants
Métis	White
Mi'kmaq	White European
Black	White anglo saxon
Black Canadian	Quebecois blanc
Mixed race	Caucasian
Jewish	Settler Euro-Canadian
East Indian	White settler
Middle Eastern	
African	6% of participants
African Canadian	Human
Non white	Irish/English
Asian	Didn't answer
S Asian	
SE Asian	
Hispanic	
White presenting	

Participants described a range of pedagogical strategies and approaches to incorporate anti-racism in their teaching and learning, and unfortunately describe or demonstrate even more barriers. While I was at first uncertain of the meaning of this difference, I came to understand it

as likely an accurate depiction of the anti-racist struggle. If our efforts and strategies were more sophisticated, practiced, and deeply integrated, this is to say, as complex as the web of barriers, then explicit anti-racist nursing education wouldn't still be in its relative infancy. The following 11 sub-sections demonstrate methods of critical engagement and also render visible gaps in the pedagogies of the participants or their schools of nursing. I've included the whole range of pedagogy-focused data from my study to act as a map for our focused attention. Further, since participants say anti-racist discourse and practice is often unsafe for them, it feels important to represent the breadth of experiences and concerns here in the literature. I privilege participant voice significantly to be accountable to the participants, and as a measure of validity for my analysis.

Lastly, I want to account for the cases where participants didn't offer any strategies; 16 respondents, 11 of whom are racialized as white, said they don't engage in anti-racism in terms of what or how they teach. Some said it wasn't included in the curriculum, others said it wasn't relevant to their course topic, a participant that is racialized as marginal said they haven't had the opportunity yet, two participants racialized as white conceded they haven't engaged in anti-racism due to a personal lack of knowledge, and several people said they mention anti-racism in passing. Structural and discursive barriers to anti-racist engagement in nursing education, including this form of inaction, are taken up in separate manuscripts.

4.1 **Foundational concepts**

I recognized concepts the participants report teaching that can build racial literacy and deconstruct mechanisms of oppression and so have grouped them as foundational concepts of anti-racist education. Some teach about prejudice, stereotyping, stigma, global colonialism, marginalization, or oppression; some in apparent conceptual isolation, some as pieces of a larger

discussion. White supremacy, white privilege, and narratives of whiteness are addressed specifically in the data by eight of the participants. Others focus on Indigenous-specific racism or on *"the structural aspects of racism in our systems, policies, practices, and education"*. Only one person identifies the normativity of whiteness in their responses. Social location, the social construction of identities, including processes of racialization are taught by some participants:

> *"And so we've been pushing this quite hard and we've added pieces into every assignment. Talk about your own positionality. Who are you? Why did you write this? How did you write this? What do you see? Students have a really hard time doing this...to acknowledge who they are and then talk about how that changes the vision and the lens through which they see"*.

Some of the concepts used to describe how educators engage in anti-racism were named quite vaguely and as such do not provide evidence of a distinction between critical anti-racist education and rhetoric. Examples are: *"address issues of social justice in healthcare and nursing education"* and *"equip students to analyze, understand, and intervene in the system of oppression to advance equity for all people"*. Other responses are more thoroughly articulated: *"Take an intersectional approach that is grounded in critical race theory and that invites all to identify unearned privilege and unearned denied privilege. Then we question PRIVILEGE in the first place"* [emphasis in original], and *"...worked very specifically on decolonizing frameworks with white folks, so not focusing on the Indigenous issue or the Indigenous problem, or Indigenizing, but really looking at decolonizing and working with Whiteness"*.

4.2 Intersection of racism and health(care)

Educators in the study say they teach about race and racism in terms of how it affects population health, how it is present in group and individual interactions, and how it is embedded

in research practices. Many participants focus on racism as a social determinant of health (SDH), teaching that SDH's are out of patient's control and have negative impacts on health, inclusion, and opportunity. A participant racialized as white challenges deficit perspectives by locating *"the social in the foreground and not the biological or other 'vulnerabilities'"*. A few participants racialized as white include assessment strategies for non-white skin or *"discuss 'non-white' manifestations and management…[recognizing] the limitations of information related to non-white health care information"*. Some participants report working on developing students' skills to defuse or 'handle' discrimination directed at them by patients. Others work to develop 'speak up' skills so they are prepared to interrupt or call out racism when they witness it rather than participate in regrettable silence. Lastly, action or intervention by the nurse is framed as part of the professional role through mechanisms of hope: *"You are our hope to eliminate those racist attitudes and behaviours, not from the world, but just from your unit, show the people the love, show the people the diversity, show the people how to treat each other"*; through obligation: *"this narrative generates discussion about the obligation of the nurse to push against their own experiences of collusion, they can no longer pretend they haven't seen/heard, but must name it";* and through aspects of professionalism: *"…to help students make the link to healthcare and being a professional"* and *"I teach anti-racism as part of the CHNC Standards of Practice"*.

In line with a commitment to curricular and professional adherence, participants carefully articulate the intersection of racism and health to land anti-racism squarely as nursing knowledge; this is described as a strategy to make the learning indisputably relevant. However it is also employed by some so they can avoid politicizing nursing, or avoid being accused of being political. The former of which is evidence of enduring magical thinking that nursing could be

anything but political, and the latter evidence that educators taking up anti-racism face criticism from colleagues, both of which are also represented in Dr. Valderama-Wallace's study (Valderama-Wallace & Apesoa-Varano, 2020).

4.3 The counter-narrative: Critical history and first-person story-telling

Participants describe broaching a range of topics that work to disrupt the historical erasure of imperialist colonialism in Canada that relegated Indigenous people to a non-human status and installed White Christian hetero-patriarchy as the dominant social and structural location, and the resulting enduring Canadian and nursing narratives. So even though none of the participants named these methods as providing a counter-narrative, I have defined them as such. Some participants described naming racism, exploring the realities and legacy of colonization, and broadly, providing a critical Canadian history to counteract what Bruyneel names the 'work of settler memory' (2021). Other participants said privilege, racial identity, positionality, and settler positionality specifically, are topics addressed with their students: "*I teach a course that focuses on themes such as identity, social location, race, to help students locate themselves in Canada. I also teach about systemic racism in Canada, colonization, and the legacy of colonization"*. To contextualize nursing as a site of racism a participant racialized as white said they "*challenge traditional representations of nursing and share the racist history of nursing, particularly in Canada*", and others said they incorporate anecdotal narratives of racialized and often violent healthcare interactions in order to confirm for students that racist nursing is a real thing, *"I thought everyone knew that story and many of them were like, 'Really? This really happened?' They couldn't believe it like you were making it up or something."* Only two participants however specified that they explicitly draw attention to the epistemic exclusion that results from white supremacist marginalization with their students. One participant racialized as white said

they make it clear to students that the lack of Indigenous counter-narrative in nursing education is due to omission, and not to a lack of available material: "*...we want our students to understand that they have been named for some time, but we as nursing educators, we have not done a careful job of including those kinds of resources...*". It should be noted that this counter-narrative theme had the least amount of data coded to it as compared to the other themes described in this section, so it could be theorized as an underdeveloped strategy.

First-person accounts of lived experience of racism, or counter-storytelling, is a central feature and tool of critical race theory. Participants that are racialized as marginal employ this tool to educate their students about the reality and impact of experiencing racism. They use their own stories as invitation to students with lived experience of racism to also share if they are comfortable. A participant says this, *"I purposeful[ly] incorporate my own non white position at times to encourage others to share diversity in perspectives to disrupt the predominance or dominance of ideas. I find over the years students are more and more comfortable with this."* On the flipside, several participants racialized as white say they are careful to avoid making students that are racialized as marginal feel they are at all responsible for educating their classmates by sharing their personal stories. Some white educators seek and host guest speakers with lived experience and others use videos or articles to provide the first-person accounts for their students. Knowing that nursing education remains a predominantly white environment first-person story-telling is likely under-employed as a critical race pedagogical strategy. Further, where white educators are motivated to use this strategy there likely exists a high potential for tokenizing the fewer faculty that can authentically offer it.

4.4 Applied theoretical lenses

Where participants were asked to delineate the *what* from the *how* of their teaching, many spoke of how they apply theoretical lenses to their teaching practice and less so explicitly taught students to do the same. Anti-oppression is named as a lens that educators teach from in concert with equity, social justice, and anti-racism, and it is also described but not named, here by a participant racialized as white: *"I ask my students to name all that they see that warrants unpacking … we must listen and identify all those subtle ways that a person entering the healthcare system might feel marginalized and 'less than'."* Critical pedagogy is named alongside feminism, social justice pedagogy and cultural safety, and informed by the work of Jacques Rancière and Nixon's coin model of privilege. One participant racialized as white illustrates their application of critical pedagogy with their refusal to use proctoring software. Several participants racialized as white describe (but don't name) an anti-colonial lens by saying they name and resist the Eurocentricity of higher education by problematizing white western concepts such as *"normal child development"*, grading practices that don't account for power or context, and course designs that reproduce systemic racism. Two participants racialized as white describe democratic andragogy as lens grounded either in shared power feminism or heutagogy (self-directed learning). Other theoretical lenses were named but to a lesser extent; cultural humility, Indigenous pedagogy, trauma-informed approaches, a pedagogy of discomfort, and a-racial nursing theories.

Lastly, in a question that asked participants to select the most valuable five of 16 approaches towards developing anti-racist nurses, intersectionality was the approach most selected. Throughout the study intersectionality was named either in terms of what educators teach, *"I teach population health and I try to address structural issues around racism from an*

intersectional perspective (content usually focused on racialization, sexual orientation, gender, age)", or in grievances about what is missing from nursing education,

> *"I think what happened with Black Lives Matter is the solidarity across people that have been marginalized based on their gender, race, ethnicity, class, etc. And I guess for me, that's what I don't see in curriculum and teaching and education. I don't see that overlap. I see just a need for this push toward Indigenizing without knowing what that is"*.

4.5 Instructional methods

Where participants named specific instructional methods or tools, discussion is the most named method, followed by case studies, applied critical analysis, and first-person counter-narrative. Those participants who said they use discussion and case studies did so cursorily without articulation of how they employ discussion and case studies as pedagogical tools, nor did they articulate how they ensure the methods themselves *are* anti-racist, meaning that they don't inadvertently reproduce stereotypes or marginalize people in the process. Participants engaged students in critical analysis of their course material, their social identities, Canadian history, current events, scholarly sources, and statistics-based research. A participant racialized as white works *"out loud"* to model critical analysis, and two participants that are racialized as marginal engage in deconstructive critical analysis of students' comments or perspectives to interrupt the reification of harmful concepts or stereotypes. Self-reflection also featured dominantly in participant responses, which will be surprising to no nurse educator. Some participants describe modeling self-reflection, some cursorily say they use reflection as a tool, and one participant racialized as white says:

> *"I engage students in discussion about being continually reflexive about their own positionality and their own privilege. I talk about language, encourage students to look at*

how their language contributes to perpetuating colonial practices, I encourage critical reflection and challenge myself and students when we inadvertently say/do things that perpetuate racism…".

Participants report a strong focus on the power of language to harm and to accountably disrupt hegemonic environments. Many participants say they attend to their language use while teaching and in their course materials to avoid microaggressions, reifying stereotypes and stigma, and being exclusionary. Others talked about using explicit language (such as racism, colonial, and white supremacy), in classrooms, school documents, and mission statements to disrupt hegemonic 'softening' of language in service of whiteness, professionalism, and fragility.

A relational angle described is being human and vulnerable with students about participants' own struggles with anti-racist learning or living with racism, rather than upholding a manner of professionalism by staying distant and not engaging in self-disclosure. Other methods employed are centering learning on current affairs, *"I heavily pull from current and past social contexts, ranging from the civil rights movement to the me too movement"*, practices of embodied learning to *"help touch the hearts and minds of students"*, and universal course design, *"I get to know my students and adapt the classroom based on individual differences, role modelling anti-racist stance"*.

One method mentioned in the study that I worry has enormous potential for harm in this context are debate activities. The participant didn't provide a description that would allow a contextualized analysis of the application, but in the context of white supremacy and oppressive stereotypes, narratives, policies, and norms alongside the propensity of debate activities to encourage 'playing the devil's advocate', I imagine this activity to be a minefield of harm.

More specific to facilitation skills one participant described the need to preface challenging material with clear learning objectives. This creates a contextual container so students aren't thrown into something challenging without knowing how to engage with it. Another participant regretted not knowing how to elicit vocal engagement from quiet students, so she could understand what their learning and support needs were. And another participant racialized as marginal identifies a lack of capacity to manage confrontation in the classroom as a possible deterrent: *"I put myself in a position where I might get more confrontation, and so not everyone wants to do that…We don't have enough support to have these conversations in our classroom. We don't have the capacity, the learning, the expertise for dealing with that."* Further, on the topic of facilitation is the specific skill set required to teach anti-racism across an extreme breadth to meet students where they're at. Lastly, clinical instructors, who arguably have the least amount of educational preparation for teaching, are struggling to respond effectively to instances of racism experienced by their students especially if there are also employees of that clinical site and the racism experienced originates in one of their colleagues.

4.6 Absence in curricula

Many participants reported that anti-racism is not in their curricula in any substantive nor systematic way. Some participants say there is content that could be anti-racism, but its educational impact is unclear because it isn't explicit anti-racism. Some participants critique a lack of willingness on the part of leadership in nursing and universities generally to make anti-racism a priority. A central feature of the absence of anti-racist curricula seems to be a consensus that there isn't room in the nursing curriculum to add anything, so there isn't time in the rigidly structure semester to introduce new topics, especially one such as anti-racism that requires significant time and resources to appropriately address its complexities. Several participants said

they have to add the concepts into their courses, leaning on the knowledge they have from their lived experience, or that they have undertaken independently. *"So in so many ways we're often just like, like myself, I'm winging it. I'm winging it with some background but not everyone has that background. And so when that happens, they don't really know how to."* A couple of participants said they assess the content of their courses, prioritize the critical perspectives and make room by replacing some content with anti-racism. Other participants said they don't know how to include it meaningfully in their courses in part due to a *"lack of existing nursing specific research to guide WHAT content to deliver. Racism in nursing education is well established, but the action piece, the how-to-address-in-the-classroom is lacking."*

Some participants however, describe mechanisms of accountability such as seeking education to develop their own knowledge, and modelling this self-responsibility and inward direction of anti-racist effort to students, and seeking curricular feedback from advisory committees and the students themselves.

4.7 Bias

Nursing scholarship and educational resources are produced by nurses who are generally in the academy. Since whiteness floats to the top and is accompanied by epistemological privileging of English language scholarship from the Northern hemisphere this results in most nursing resources representing very narrow perspectives, namely white and Euro-centric perspectives. Beyond naming this process of epistemological supremacy participants also named an apparent inability or unwillingness to critique nursing knowledge, despite it's obvious limits. Several participants expressed concern over how the embedded racial bias in artificial intelligence-based nursing tools and those used in learning laboratory settings in nursing education silently reproduces white supremacy in nursing practice. It is noted by many

participants that these gaps in nursing education are apparent to students and that they are making demands for a better education.

> *"A prof was showing a guideline on …wounds or something, and it said on white skin and on other skin. It was the white and others. And the student raised, well, that's racist. She wanted to have that conversation and the prof limited the conversation as to, 'well I don't know how to answer this. I don't know.' …and then in their head, they're asking – they lift up their hand and they say, 'and how would that materialize on Black skin?' And to have an answer that says, I don't know. Even from any position, you'd be like, well you're clinicians…you must have seen somebody else that's not white. So how do you do your assessment? How do you know that your assessment is right?"*

There is a lot of energy put towards mitigating harm from established nursing literature and resources by participants. Participants describe using discernment to prioritize and highlight some curricular content over others, and at times subvert course content altogether where it is seen as harmful. Some add or change assigned readings to include a range of perspectives (or just racial authorship), to include *"multicultural themes, [including] guest speakers from ethnic minority groups"*, to specifically add perspectives on Indigenous health, to *"present a balanced and critical examination of power and privilege"*, or to specifically add literature from anti-racist scholars. Some participants said they include resources authored by people such as "*a Black woman"*, "*a non-binary person"*, "*Indigenous older people, Indigenous health care providers*" and "*Indigenous scholars [such] as Lisa Bourque Bearskin"*. Several participants say they take on the role of providing resources to colleagues either directly or department-wide on faculty servers. A participant that is racialized as marginal says they *"have to dismantle most resources to teach in different ways"* and another says,

"So I find that it feels like an ongoing battle when it comes to even just getting people to think outside of some of the traditional approaches to classes, to materials that we're using for teaching, take a critical lens to some of the tools that we're using, and who's not included in any of those tools."

Participants with autonomy in their teaching say they design courses to include critical anti-racist content whereas a participant racialized as white without that same autonomy says: *"I apply a critical lens to the curriculum I am provided as a sessional and I work to reduce the harm that can come from racist text/content"*.

The examples of data given in this section demonstrate a range of applied criticality in how and why educators curate educational resources. Recognizing harm in resources is one skill, but knowing how to replace them, having the literal resources to replace them with, and the resource of agency with which to do this labour requires much more structural stability and engagement, which not all educators are privileged to have (Bell, forthcoming). The instability that follows the absence of anti-racism in curriculum and resources is taken up in the following section and in the discussion.

4.8 Superficial understanding and application

Participants variably display and describe superficial understandings of racism, anti-racism, and Indigenization. Two white focus group participants couldn't articulate whether anti-racism was differentiated from Indigenization in courses in their individual schools which could mean they didn't have broad knowledge of what was being taught across the program, or it could mean they didn't have the conceptual language to tease them apart. There were critiques of programs generally teaching acceptance, kindness, and individualism rather than naming and deconstructing racist Canadian policy like 'Indian' residential schools.

"We'll use the language and we won't make the change, because the change is threatening to so many people. I think that the conversations about indigenising, what does that really mean? It means that we're going to add indigenous content? Are we going to understand where it comes from?"

Accreditation and regulation processes are seen to reduce anti-racist education to a check-box, which encourages content inclusion even if at the bare minimum, but doesn't employ accountability measures for anti-racist pedagogy, nor changes to the school climate. The broad uptake of land acknowledgements was described by participants variably as either a critically disruptive strategy or a ritualistic and rote performance. A subliminal example of misunderstanding the purpose and power of a land acknowledgment in a Canadian setting is a faculty meeting that applauded when someone did their own land acknowledgement in place of the ritual institutional reading, but in the process erased Indigenous people and their colonization through a story of legal immigration and *"starting at the bottom"* of society. There is concern about tokenizing Indigenization rather than employing it as an anti-colonial and anti-racist strategy for epistemic reparation.

"I don't actually want to see us indigenizing in the way that its more tokenism and more a way of this is just something that's in vogue and in fashion and we need to do this right now. I constantly remind myself and many of the other leaders within my institution that as we move forward…"

Further critiques about superficiality are that anti-racism is not framed as a concrete safety-issue but rather a 'nice-to-know' topic, that educators are only willing to talk about racism in terms of health outcomes, or that educators don't bring in real world examples to contextualize racism, but rather allow it to exist only theoretically.

"If we were truly approaching that from an anti-racist lens, and we would be talking to students about the impact of the Indian Act, and we'd be talking about treaties, and how all of those pieces have led to some of the healthcare challenges today, we'd be talking about the issues around non-insured health benefits and lack of knowledge by providers about what follows with under the non-insured health benefits and how do you help people be able to connect with those. And so I think when we're not doing that, then we're absolutely not approaching it from an anti-racist lens, because we're not -- to me, and this is just my thinking about this, that we're not equipping them with what they need to have to be able to take apart all of those layers of colonial policy and law and practice."

4.9 Primary or sole focus on Indigenous-specific racism

This is a contentious section and I will take it up thoroughly in the discussion, albeit from my white perspective. To be clear at the onset though, no participants in this study refuted the need for Indigenous-specific anti-racism. Many participants both white and those with marginalized racial identities expressed confusion, pain, and disappointment though in how anti-racist education seems to be locked into Indigenous health courses or solely focused on Indigenous-specific racism.

"…what do I want to say, my worry is that with this movement, and I don't really know what indigenizing means or what it would look like, but what does it mean for people that have experienced marginalization who are non-indigenous but continue to experience it every day? And if we're indigenizing but we're still culturally not safe, then what happens with other students and faculty that experience who are non-indigenous as well."

Contrarily there were also participants in support of a focus on Indigenous-specific racism.

> *"We cannot start with anti-Black racism or anti-Asian racism or misogyny or all the other pieces that exists in our system, because as long as we're starting elsewhere, we're replicating Indigenous harm…as long as we start with anti-Indigenous racism, we're going to get to all the rest of it, because it's a necessary piece of the conversation. But if we start somewhere else, we won't necessarily incorporate those other people, so ensuring that we start with anti-Indigenous decolonizing, anti-racism work."*

But it is apparent that this position isn't concretely founded because the same participant later in the focus group said this:

> *"because we're talking then about individualistic experiences of racism based on the oppressed as opposed to being willing to talk about White supremacy. And I think that's really where things shifted for me and my understanding is that White supremacy and patriarchy kind of go hand in hand, and when we look historically at the origins of all of the folks, Islamophobia or anti-Black, anti-Asian, I mean, we can look globally at -- it was White colonial power, male power that created the harm. And so I think it is deflecting from that conversation by focusing on any one individual group within that. It sort of dilutes the conversation and very intentionally…"*

So there is contention between devoting curricular space to Indigenous-specific racism and addressing racism as an oppressive structure that harmfully impacts many differently racialized people **when it means that it's an either or, and not both.** *"For the first time, I would say in the classroom setting, I had a chance to address it, but it was really about the Indigenous population."* Where one group of people who are racialized harmfully is seen to be the focus for anti-racism, it invokes and reifies a sense of a racial hierarchy which causes further racial harm:

"there is a hierarchy there…and sad, but true, anti black racism is at the bottom of that hierarchy".

4.10 Whiteness and the construct of expert

Whiteness as a standpoint generally is understood by, and demonstrated by, some participants as a significant limiting factor in providing anti-racist education. A lack of insight into the mechanisms of white privilege is a direct barrier. One participant acknowledged that they come from privilege and that they are uncomfortable with anti-racism content and further that they don't know how to make it relevant, as if anti-racism weren't relevant in every situation. White fragility is both named and described by participants as a barrier to beginning to engage in anti-racism, or to continue engaging after they encountered *"negative reactions from some students (both racialized and non-racialized students)"*. One tenured participant racialized as white addresses the fact that white comfort has been prioritized in perpetuity and that this sidelines anti-racist discourse:

> *"The few minutes of pain that you're going to have to navigate is nothing. Get over it. And that's a very uncomfortable position to take, but I'm also at that point and I'm getting closer to retirement, and have come to the realization that sometimes you have to say uncomfortable things and people just have to deal with it."*

Several other participants racialized as white who aren't held back by their whiteness shared a concern about speaking about experiences that aren't their own as one person articulates here:

> *"I intentionally weave it throughout my course and students see that. As a white settler educator I have to be careful to share appropriately (nothing about us without us) while still weaving it intentionally into each class. I'm learning and getting better each term but I'm still making mistakes that I have to own and move past."*

One participant racialized as marginal evidenced this concern when they said that white people appropriate anti-racism projects or ideas *"…as they 'know best'"*; the inevitability of their expertise unspoken but habitually assumed in a move of white supremacy. One participant racialized as white named the risk in being overconfident: *"…and that was what made me go away from our meeting and cry the other day too, because if you think you've got it and you don't, then all you're doing is perpetuating these things on students."*

Last of all and somewhat fundamentally is how the construct of expert is an actor in anti-racist nursing education. Participants who named this dynamic expressed that the necessity of being the expert teacher holds nurse educators back from including anti-racist content in their courses because it feels there is no room for error; that the professional nurse identity is at risk when they are not the expert. The complexity of anti-racism as an applied knowledge and beingness and not just rote content increases the margin for error. Though participants did not name this explicitly, where they allow their lack of knowledge to deter them they reveal this complexity in that much of teachable nursing content is accessible in textbooks and guidelines and the resourcefulness of nurses is an otherwise defining characteristic. One participant said this same framework of no-room-for-error is then tacitly (or not) learned by students, which may impact the authenticity of their engagement in the learning. A participant racialized as marginal also critiqued the normative positioning of established white nurse scholars as experts in anti-racist nursing despite their very recent uptake of the work, and despite there being Black, Indigenous, and more nurse scholars racialized as marginal that embody authentic expertise. The position of expert is an as-of-yet undeterred identity construct formed both in the professional knowingness of being an educated and licensed nurse and in the authority bestowed upon post-secondary educators. These are both confounded by the sense of inherent expertise that grows

through being centered and normalized in a culture and politic of white supremacy, so where people are in all three of these social positions such as white nurse educators, the construct of expert may require particular critical analysis (this paper potentially as exemplar because I am also all three).

4.11 Comfort vs safety

The depth to which educators are engaging in anti-racism is largely dependent on their comfort level with the material and theoretical perspectives, and their intrinsic sense of urgency about it. Participants racialized as white voiced a variable range of confidence and commitment by questioning whether they were the 'right' people to be teaching and also by claiming responsibility for shouldering the burden of anti-racist teaching.

There exists a dichotomy here where it is important to uphold a 'nothing about us without us' teaching practice, as one participant said, but the overwhelming whiteness of academic nursing means that the fewer faculty racialized as marginal are targeted for much of the anti-racist work regardless of the focus of their work and interests.

> *"Much of the faculty are white and it will come from that lens. However they may place the responsibility on the few BIPOC members with no critical race theory background. There is the fear that it will not be taught the same way by all faculty members depending on their comfort level."*

Beyond comfort that centers coming to terms with privilege and ignorance, is comfort associated with risk and safety. One participant highlights that in an institutional environment dominated by whiteness it isn't always safe for faculty racialized as marginal to be outwardly and disruptively anti-racist, which is of course, already well established in the literature (Beard & Julion, 2016; Hassouneh et al., 2012; Valderama-Wallace & Apesoa-Varano, 2020) and the

structural piece of the power job precarity holds over anti-racist educators is taken up in another manuscript (Bell, forthcoming). A telling feature of the motivations of participants to join this study is that many of them attended for the opportunity to speak candidly about the challenges they are facing and the harmful environments they are working in. This is to say, that some participants said they do not even have a safe place speak candidly in their workplace, let alone disrupt the status quo.

On the matter of student safety I need to contextualize again that this study only engaged with nurse educators and so the following data cannot be understood to actually represent whether their students felt safe or unsafe. Some participants say they work to create a safe and respectful environment through a range of discursive methods including making class rules with consequences at the beginning of term, treating everyone fairly and equally, and claiming their classes are 'safe spaces'. There is variation in how 'safe space' is conceptualized with some participants framing safety as not being judged or disrespected, and others framing safety in terms of a supportive environment for feeling challenged or uncomfortable. Several participants who do not currently engage in anti-racism or anti-racist teaching say they don't know enough to do so safely. Others said they are aware that *'BIPOC'* students may be harmed in classroom discussions about race and racism, and they wish they knew how to prevent it. One participant racialized as marginal said the hierarchy of marginalization, which can pit one marginalized person against another, is a source of harm in the classroom during discussions of racism. One participant racialized as white noted that the Indigenous students in her classes rarely self-disclosed their Indigeneity in small group discussions, which she interprets as a response to unsafety. The overall concern (or reality) is that as us educators work to undo and prevent harm we are doing more harm, but maybe differently. As a result of racism, classism, and colonialism,

the people who are nurse educators are generally a privileged bunch, and so the mobilization of anti-racist pedagogy here is like squeezing a square peg through a round hole.

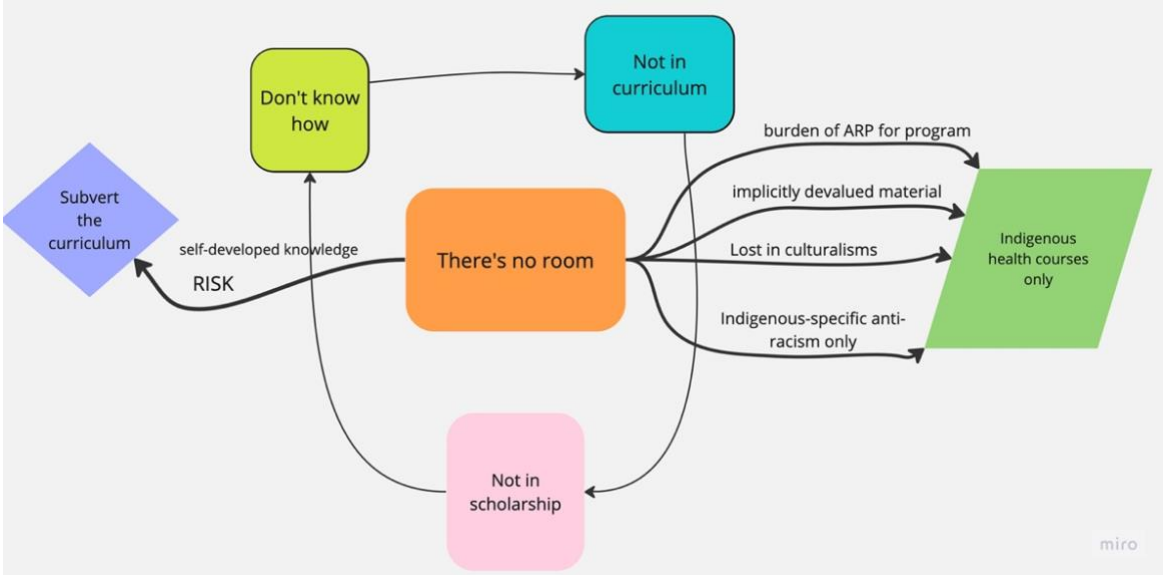
5. DISCUSSION

There are many threads to pick up on and discuss, and many of them have already been addressed in other literature and so I elect to focus on what I feel is still emergent in nursing education spaces, particularly in this moment of essentially mandated curricular development. First the implications of the absence of anti-racist pedagogy in curricula, second the (mis)conceptualization of Indigenization, and last the narrow application of anti-racism.

5.1 Absence

The absence of anti-racism in nursing curricula creates a cycle of chaos for nurse educators here illustrated in Figure 2. One that I see has two exit options that are neither safe for all educators nor systematically effective.

Figure 2: Cycle of chaos



The multi-directional cycle of chaos centers around the discursive object ‘there isn’t any room in the curriculum for anti-racism’. The curricular subversion exit route requires some

institutional and arguably professional subversion in order to teach this fundamental nursing knowledge. Subversion carries risk, and in the context of well-established job precarity in academia this risk may be untenable for many educators, or at the very least, a deterrent. Beyond the subversion of curriculum, this exit route also requires a substantial knowledge base to effectively and safely introduce anti-racist concepts and information, and this, I've already established, is not a given in educators. A second exit route is to silo it in courses about Indigenous health, or in initiatives under the umbrella of Indigenization. Depending on the content, context, and language with which this anti-racism is applied, it may be transformative anti-racist education, it may be literally lost in translation, or it may risk being narrowly applied and/or understood to only invoke Indigenous-specific anti-racism. A plausible outcome (that many of us have already witnessed) is that students (and faculty) do not engage thoroughly in this education because they are implicitly taught that it is not central to their core nursing knowledge. Even more insidiously, if it is not a critical deconstructive anti-racist pedagogy that exposes implicit Indigenous-specific racism, then student's (and faculty's) implicit racism towards Indigenous people may devalue the content just as Indigenous people are de-valued systemically.

Further, this study demonstrates a haphazard application of anti-racist pedagogy, where it can even be appropriately labelled as such. Though many of the participants of this study demonstrated that they work to provide an anti-racist education, the fundamental concepts described were provide piecemeal from across the participants. Critical race theory did not feature dominantly as taught content, and counter-narratives as a critical race strategy was not named by anyone despite being a central tenet (Delgado & Stefancic, 2001). Strategic critically-minded instructional methods are not well articulated by participants in this study, and so a

generalized deduction is that they are not well applied in nursing education. 'Discussion' is named as the most common instructional method, but without articulation of an inclusive and anti-oppressive engagement strategy. I wonder then if 'discussion' isn't signified rather than actualized as a signifier. A common classroom experience of mine is an instructor and three to five habitually and predictably vocal students comprise the spoken elements of a 'discussion' while the remaining 25-100 students sit in silence. Transformative learning theory values discussion as a tool for refiguring conceptions of self and world but also accounts for the way power mediates the possibility of engagement in discourse (Mezirow, 1996). Kumashiro (2000) says that we can never know the extent of what is learned in an educational exchange, but as one participant reflected, we probably ought to have strategies in play to engage, or know that we are engaging all of our students in this charged context. Lastly, explicit anti-colonialism as practical and theoretical perspective is also underdeveloped in the study data, despite significant national pressure to respond materially to both the TRC and UNDRIP. It really ought to be interrogated whether any initiatives labelled as response to the TRC or UNDRIP that are not explicitly anti-colonial have any merit.

5.2 Indigenization

What do nurse educators understand the goal of Indigenization in nursing education to be? Who is it by and for? If non-Indigenous nurse educators don't know what Indigenization is, nor what its goals are, then can they (we) say it's really happening in nursing education? In some places the checkbox is boldly ticked, but *is it* really happening? And is it un-done if some nurse educators reduce it to 'dress, dance, and diet' cultural knowledge? And then still call it anti-racism? Indigenization and anti-racism have obvious overlap, but are not the same thing.

I understand Indigenization in educational settings to be a global anti-colonial strategy of epistemic justice and reparation. It is described as "a process whereby knowledge is produced within the institution from an Indigenous perspective" (Bopp, Brown, & Robb, 2016 in Harder et al., 2018, p. 24), or as "providing a new understanding to Eurocentric education and knowledge systems by bringing elements of local Indigenous languages, beliefs, and ways of being into focus" (Battiste & Henderson, 2016, in Boisclair, 2019, p. np). Every nursing school in Canada (and the United States, and Australia, and, and) is on Indigenous land on which millennia of knowledge were developed and lived. Indigenization as inclusion of Indigenous knowledges and ways of being is not just *honouring* as in giving it a place on the curriculum blueprint, but as in exploring it as valid and valuable knowledge. "Bridging this gap/opportunity between Indigenous and non-Indigenous nursing knowledge serves to enrich and extend the nursing discipline…" (Kennedy et al., 2021, p. 10). Beyond and more importantly than how I and other settlers might engage in Indigenized spaces, it opens structural and discursive space in colonial institutions such as higher education for Indigenous people to determine for themselves what that means and how they want to live into it. It's about sovereignty (Dorothea Harris Good, 2023, personal communication). Any iteration of anything in Canada that resists Indigenous people showing up in their full humanity and with sovereignty over the development and expression of their epistemology, ontology, and axiology, is just more colonialism. Since Indigenous nursing knowledge grows between Indigenous nurses (Dr. Mona Lisa Bourque-Bearskin, in Boisclair, 2019) can schools really Indigenize without the significant presence of Indigenous nurses (this means more than a tokenized few)? Would this not just be more of the extractive colonialism identified by Ali Drummond (2020)? They say that if Indigenization isn't benefitting Indigenous people, then it's being applied in service of the institution, and thus is extractive colonialism.

Indigenization isn't and can't be the only anti-racist strategy a school employs. So why are Indigenization and anti-racism being conflated as a unified concept so readily in the data from this study and presumably more widely in the field? Figure 3 is a dated analytic memo of my sense-making around the conceptualization of Indigenization as a sole anti-racist effort in nursing schools; it centers a white perspective.

Figure 3 An analytic memo

Nov 21 - Why so much uptake of Indigenization? BECAUSE ITS EASIER than anti-racism. We can add content and a so-called indigenous lens but we don't have to do the personal work of deconstructing our white supremacy and bigotry

feb 24 - it adds Other, but doesn't deconstruct Other
So Indigenizing doesn't fit with a deconstructive educational paradigm - what is it? How does it fit with transformative learning?
its about relationship
reconciliation
epistemic justice
and extractive (!)

> *"So we take these things in our education and I think everywhere, and then we sort of apply them but we don't think deeply about them. We don't unpack them and we don't think about our own positionality…all of those words you might want to use, but we don't really dig in and say, 'what does this actually mean and what does it mean for our teaching and for our students and for ourselves?'"*

Are we (nursing education and white folks in particular) leaning on language we don't fully understand and don't apply thoroughly in order to avoid doing more personal and more disruptive work? Who does this benefit and who does this harm?

5.3 Anti-racism

I center myself here in a move of accountability since analysis from my whiteness about the exclusion other people feel when anti-racism is siloed in pockets of Indigenous education needs to be bound by the limits of my experience and not projected onto any other standpoint. Let this argument not be received as a reproduction of equality rhetoric; I want no part in the racist all-live-matters discourse. And this is certainly not a denigration of resource allotment towards Indigenous health and education which *necessarily includes* Indigenous-specific anti-racism. It is an argument for anti-racism as fundamental education for all of us to better understand how we are actors in white supremacist colonialism so that the anti-racist nursing care that the graduates of 2024 and beyond provide attends to all people who experience and are affected by racism.

Beyond the Indigenous-specific racism that lives in me, as a white Canadian settler, the anti-Black racism that lives in me also needs explicit attention. The anti-Asian racism that lives in me also needs explicit attention. I am not unique in this as a white person, as a nurse, and as an educator. While anti-racist pedagogy that only takes up operationalizations of Indigenous-specific racism will likely give me the language and fundamental concepts of how racism operates, it won't address the particulars of anti-Black or any other racism. The rendered invisible racist stereotypes about Black or African diasporic people that I have absorbed for all of my living years do not get deconstructed in an educational container that only addresses Indigenous-specific racism. As a white person it is important to me to understand how I can

cause, and thus work to mitigate, racial harm towards anyone racialized as not white. And I want that social and political knowledge today, not at some nebulous time in the future once we've solved Indigenous-specific racism. If we are only teaching to undo Indigenous-specific racism, is it because it's the only mandated form?

Anti-racism (anti-oppression broadly) is fundamental nursing knowledge. Foundational. The soil that all nursing knowledge should grow from. Anti-oppression is the protection of human rights. It comes before bed-making, before elder care, before sanitized nursing history, before introductions to professionalism, before pharmacology. We can't fix racism with anti-hypertensives or insulin. We can't fix Black maternal morbidity with more pre-natal classes. If these are the interventions we are employing to treat racism-induced ill-health, then we are directly colluding with systemic racism. If oppression were treated as the primary cause of ill-health and death that it is, our students would be front loaded with this learning before they are asked to understand health trajectories at all.

Imagine nursing students all took a required social science course on oppression and a political science course on colonial law and policy before they began their specific nursing courses. Couldn't these be framed as essential pre-requisites? If (the Royal) we don't have adequate knowledge, and we don't, wouldn't the most professional, accountable, and responsible thing to do be to employ an actual expert, such as a nurse historian (Flynn et al., 2021), sociologist, or the like? An interesting contradiction to the study participants leaning most heavily towards intersectionality as an anti-racist approach, is that interdisciplinary knowledge was the *least* valued in that selective questionnaire item. The aversion to interdisciplinary knowledge in nursing has everything to do with power and nothing to do with health or justice. Historical, anti-racist, and anti-colonial interdisciplinary knowledge is far more important than

the poetry 101 course I took to meet the English course requirement in my undergraduate nursing program. It would have helped me become an anti-oppressive nurse in 2003, instead of starting my knowledge journey ten years into my nursing career. Imagine how much more room there would be in (yes, Indigenized) courses about Indigenous health to explore and understand the intricacies of anti-racist, anti-colonial, and culturally supportive nursing care if the educators weren't responsible for introducing students to the concepts of whiteness and systemic racism? Nursing students should not be learning about colonialism and racism for the first time in their third of four years of education. I argue here for complete re-conceptualization of nursing fundamentals. Anti-racism needs to be spread across and through nursing education, not sprinkled into check-boxes. Relegating all anti-racism to courses about Indigenous health or community health courses (Valderama-Wallace & Apesoa-Varano, 2020) structurally and discursively limits its conceptualization and application. Such narrow inclusion feels both irresponsible and lazy. It also burdens educators of these courses with high conflict work that is everyone's responsibility. The hierarchy of nursing knowledge and practice reflects the hierarchy of humans and human experience we say we are working to overcome.

5.4 Limitations

Throughout the design, implementation, and analysis of this study, my structural position in Canadian whiteness has unavoidably figured into its shape and results. In the development of the questionnaire and throughout my writing of the results I sense that I have made 'anti-racism' a sort of discursive object by saying it so much and talking about it as if it were a self-contained unit of education or knowledge. This might have affected how participants constructed it in their responses to me and with each other. Lastly, in retrospect an explicit interrogation of

Indigenization as concept and process, as it arose as a problematic in the data, would have provided much clarity on how the participants understand its application.

6 CONCLUSION: Using words to build

I am reminded of the impact of using our words to build rather than tear down. I (re)learned this from the writing of Elder Dr. Skip Dick from the Songhees Nation (University of Victoria, forthcoming), and I might have to learn it again. I am aware my sense of responsibility to not be a white nurse apologist brings an edge to my work. There *is* good work being done. And, collaboratively taking care with our words to build up anti-racist capacity in nursing education will require more clarity and intentionality. Nurse educators should be able to articulate a clear and intersectionally supportive pedagogy that deconstructs race, processes of racialization, the impact of colonialism on racial stratification, the historical use of racial hierarchy in the professionalization of nursing, and the broad intersections of racism and health. This study offers data that we are not there yet, in large part because this is still not a curricular priority in and across schools of nursing. The application of such a pedagogy often is, but shouldn't be relegated to a discrete one-time course because it is foundational and unendingly relevant nursing knowledge. Anti-racist pedagogy should not be sprinkled but spread, edge to edge and all the way through. Educators need to get clear on the purpose and function of Indigenization and not uncritically conflate it with anti-racism especially if anti-racism isn't taken up anywhere else, nor applied to anyone else. Leadership in schools of nursing should address these inconsistencies in conceptualization and in pedagogical application so that valid processes of Indigenization are not co-opted and confused and so that nurses can identify and mitigate racism towards anyone harmed by it. Lastly, all of this needs (more) urgent attention, and I acknowledge that none of this is simple or straightforward. I sought to map the experiential landscape of anti-racism in

Canadian nursing education to enable us to identify what to work on. We've all got to do something, so let's each find the most accessible entry point to re-configuring nursing as anti-racism and get to it.

Chapter 5: Conclusion

This study sought to understand how nurse educators are engaging in anti-racism and what barriers exist that interfere. As a cohort, these educators work to provide anti-racist education through teaching foundational concepts and theories of anti-racism and anti-oppression, articulating the intersection of racism and health, using counter-storytelling as critical pedagogy, and seeking anti-oppressive instructional methods.

As described throughout the dissertation, the barriers educators face are immense and multi-faceted. Employment in higher education is precarious work until tenure is secured. Structures of promotion and retention devalue anti-racist work and the institutional environment is a power-laden rigid wheel stuck in the path of the status quo. There are altogether too many white folks in positions of power, or on the ladder to get there, and they (we) continue to reproduce white supremacy in language, teaching, research, and relationship, often inadvertently, but always based in normalized Whiteness. Racial battle fatigue (Fasching-Varner et al., 2014) though not named in the previous chapters, can be used to summarize some of the experiences described by participants where they are not protected by white privilege. Regulatory and accreditation process severely limit the flexibility of nursing curricula and so anti-racism remains poorly integrated in nursing curricula, and is often siloed in one-time courses. Anti-racist pedagogy is likely not well conceptualized or applied, as there was little data pointing to innovative and anti-oppressive instructional and evaluative methods. Indigenization is poorly understood and sometimes misrepresented, and even co-opted to symbolically satisfy check-box anti-racism.

Anti-racism is disruptive education and process that doesn't sit quietly and complacently in a classroom, and so even when universities and schools of nursing say they are committed to anti-racism it is *still* like shoving a square peg through a round hole. There is tension, resistance, pain, and doubt that it will ever work.

This study contributes significant voice to scholarship around applied anti-racism in nursing educational environments. It moves beyond discursively deconstructing nurse educators and their environments to carving out a space for their complex and nuanced experiences navigating the intersection of settler colonial Canada, white-dominated nursing education, and Eurocentric universities and colleges while genuinely wanting to contribute and communicate an anti-racist practice. The study also contributes attention to some sticky points where intention and desire to contribute meaningfully don't equate authenticity and effectiveness. Further it highlights processes of performativity and marginalization within the container of anti-racism that undo the work that is being done.

Recommendations

The study questionnaire focused on applications of anti-racism pedagogically, but structural and discursive strategies also arose in written data as well as in the focus groups, although many of these strategies were admittedly aspirational. While they are not captured in the manuscripts included here, they are worthy of mentioning as recommendations from the participants. Among them were critical hiring, retention, and promotion processes, longitudinal mentorship structures for students and faculty at risk of experiencing racism, thorough and appropriate curricular input, and decolonized policy and ways of being. Participants also described engaging in informal leadership most often through the implicit and explicit education

of their colleagues, psycho-emotional support for students from positions of authenticity and vulnerability, and supporting students in subverting ineffective and harmful complaint processes.

Contained within the four manuscripts included in this dissertation are 26 further recommendations which I will reiterate here as a more concise reference point. Many of these recommendations have been made elsewhere and probably many times over, so I am not claiming originality here, but rather evidencing that they have not yet been taken up systematically.

Table 5 Study Recommendations

1. Reimagine nursing curricula in a decolonized, critical, emancipatory paradigm
2. Re-integrate social and political science courses into nursing fundamentals or pre-requisites
3. Document and disseminate processes that disrupt hegemonic devaluing of social & relational content in favour of biological and psychomotor content
4. Apply anti-racism broadly, then take up iterations of it specifically
5. Systematically apply a framework of anti-racist pedagogy to nursing curricula at the national level
6. Do not burden Indigenous faculty with all anti-racist content
7. Conceptualize racism and other oppressions as equally harmful to patients as other accepted forms of harm
8. Implement intersectional risk-assessment as a norm in nursing education
9. Hold educators accountable for their continued learning
10. Look to other disciplines for help – don't re-invent the wheel
13. Don't protect Whiteness in research reporting
14. Disrupt the white normativity of academic publishing – do not write to Whiteness
15. Don't measure self-efficacy – measure change!
16. Do not produce colour-evasive scholarship
17. Prioritize individual accountability for attending to risk of racist harm
18. Focus institutional anti-racist efforts on dismantling white domination
19. Attend to silencing processes – reject the erasure 'zero tolerance policies' create
20. Reduce precarity in nursing education employment – protective measures are required for faculty doing disruptive work
21. Decolonize the tenure and promotion process
22. Flatten power structures in schools of nursing
23. Create sustainable equity-focused HR policy
24. Build sustainability into anti-racist initiatives
25. Come right out of the University to literally decolonize nursing

11. Conduct comparative studies of method and impact of curricular integration of critical social theories
12. Develop innovative and decolonized instruction and evaluation methods to not reproduce dominance and competition

26. Remember that It starts with Me (First Nations Health Authority, 2023)

On validity

This critical, feminist, anti-racist research can be considered openly ideological in that I make no claims of objectivity and the subject of investigation is certainly value-laden. The concept of catalytic validity as research validity measure thus has resonance (Lather, 1986). The question then is whether this study both "advances emancipatory theory-building and empowers the researched" (Lather, 1986, p. 64) That many participants accepted my invitation to the study in hopes of having a safe place to connect with other Canadian educators, and then professed deep gratitude for the experience at the end of the hours long focus groups, I feel pride in having facilitated such an environment where that was possible. This might not be the change Lather refers to, but it is evidence that the research space of this study was *different* than what most of the participants say they experience day to day in nursing. Another piece of evidence towards the validity of this study is that participants invariably asked to be connected with each other by the end of the focus group sessions. The participants were hungry for inter-institutional collaboration and for a sense of community in advancing anti-racist nursing education, and the study engagement provided at least an entrée to that. I am very interested to know whether those initial relationships formed in the sessions amounted to any further support or productivity. Evidence of such would act as a final and concrete argument for the validity of my research.

Looking forward

Knowing that I have not read enough, have not considered enough, and am finding even to this minute more interdisciplinary writings that are pointedly relevant to my line of inquiry, which is alarming, disarming, and inspiring, I am working hard to accept that this is an entry point to my learning and figuring through research and that I will not cease learning from others This dissertation represents the development of my knowledge over the period of 2018 to 2023, shaped by the lived and written scholarship I've been exposed to, and this research project in the essential data and the analytic experience, but represents no more than that. Where I would like to go from here is to take up my own recommendation of systematically applying a framework of anti-racist pedagogy, and I am looking forward to making this a collaborative and applied project. "Perhaps the most pressing reason for developing a more systematic approach to anti-racist work concerns the problem of anti-racism being reduced to a meaningless slogan that is evacuated of all critical content" (Gillborn, 2006, p. 14). The ongoing risk from superficial and ineffective anti-racist teaching is untenable with my sense of personal and professional responsibility to be accountable for the impacts of white supremacy. I have advocated for decolonized andragogical engagement and non-competitive evaluation methods in my writing for the powerful *Nursing a Radical Imagination* anthology (Bell, 2022; Dillard-Wright et al., 2022) and I am committed to not just advocating for but actually *doing differently* in the academy regardless of the rigidity of the round holes I jam myself into.

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