

Hearing their Stories:
Understanding the Experiences of Canadian Muslim Nurses Who Wear a Hijab

by
Nasrin Saleh

BSN, University of Victoria, 2011
MPH, University of Victoria, 2013

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We acknowledge with respect the Lekwungen peoples on whose traditional territory the university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.

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BSN, University of Victoria, 2011
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Supervisory Committee

Dr. Anne Bruce, Co-Supervisor
School of Nursing

Dr. Nancy Clark, Co-Supervisor
School of Nursing

Dr. Mehmoona Moosa-Mitha, Outside Member
School of Social Work

Abstract

My experiences as a Canadian Muslim nurse wearing a hijab have sparked the question concerning the experiences of nurses who, in their daily practice, choose to wear a head cover, an immediate visual signifier of their Muslim identity. I wish to generate understanding of how this religious identity and its racialization intersect with gender to shape nurses' experiences with anti-Muslim racism. Through listening to the stories of ten Canadian Muslim nurses who were recruited across Canada and who wear different types of the hijab, come from varied and diverse cultural and educational backgrounds, and practice in different healthcare settings and contexts, their experiences are highlighted, and their voices are illuminated, revealing valuable insights into the challenges they encounter in their daily nursing practice. I situate these experiences within a conceptualization of Islamophobia and, more specifically, gendered Islamophobia as a form of anti-Muslim racism that is often experienced by women and girls who are identifiable as Muslims.

In this dissertation, I attend to the overarching question: *What are the experiences of Canadian Muslim nurses wearing hijab and practicing within the Canadian healthcare system?* This question encompasses three sub questions: 1) How do Muslim nurses' social locations that are produced at the intersections of gender-race-religion converge in understanding their experiences? 2) What are the power relations enacted within the discipline of Canadian nursing that produce and sustain social locations experienced by nurses who wear a hijab? 3) What are the ways these nurses resist their racialization and push against master-narratives that are constructed about them? These questions are approached using narrative inquiry as a research methodology that is informed by critical race feminism and care ethics. These questions are also explored through intersectionality as an analytical lens to unpack the complexities of these nurses' experiences.

In this study I present the nurses' counter-narrative that challenges the stereotypical assumptions about them and unveils the multilevel contextual power structures that preserve racism within the discipline of nursing and reproduce the processes of racialization experienced by nurses who wear a hijab. In doing so, my aim is to provide a vessel in which the nurses share their stories and to reclaim control over the reductionist Orientalist colonial narratives about them. It is my hope that knowledge gleaned from this study will inform the understanding of the structures and processes that produce and maintain racism within nursing with the goal of advancing transformational change in nursing to achieve social justice. I capture the counter-narrative of nurses who wear a hijab in three composite narratives that I constructed from their stories based on key storylines that I needed to unpack. By 'composite narrative' I refer to a technique where several interviews are combined and presented in one or more individual stories that are linked by a shared purpose or identity among research participants. The technique of using composite narratives to present and analyse complex and extensive data is congruent with analyzing stories as a whole instead of fragmenting them. The counter-narrative offers a point of resistance as an alternative discourse that uplifts the voices of the nurses through understanding and generating knowledge about their experiences from their standpoint.

The stories of Muslim nurses who wear a hijab bridge a gap in the literature about Muslim nurses' experiences within the current charged political environment, post 9/11 era, the COVID-19 pandemic, the Quebec ban on wearing religious symbols and the ensuing debates it generated in Canada. Their stories provide a needed and timely understanding of the implications for nursing research, policy, practice, and education to create an inclusive and supportive environment for nurses who wear a hijab. Given the interconnected nature between racism and colonialism, fostering such an environment is inherently anti-racist and decolonial.

Importantly, doing the work to create safer, anti-racist spaces for nurses who wear a hijab and to decolonize nursing which would benefit all racialized nurses.

Table of Contents

Supervisory Committee	ii
Abstract	iii
Table of Contents.....	vi
List of Figures.....	ix
List of Tables	x
Acknowledgement.....	xi
Dedication.....	xii
Chapter 1: Situating the Study	1
1.1 Introduction	1
1.2 Islamophobia.....	1
1.2.1 Gendered Islamophobia.....	9
1.3 My Story.....	12
1.4 Reflexivity	19
1.5 Purpose and Objectives.....	24
1.6 Significance	26
1.7 Structure of the Dissertation.....	28
Chapter 2: Master-Narratives	30
2.1 Introduction	30
2.2 The Racialization of Muslims in Canada	31
2.3 The Discourse on the Veil.....	34
2.4 The Canadian Context	38
2.4.1 Settler Colonialism.....	39
2.4.2 Neoliberalism	42
2.4.3 Multiculturalism	46
2.4.4 Religious Symbols	48
2.5 The Context of the Canadian Healthcare System and the Discipline of Nursing	52
2.5.1 Racism in the Canadian Healthcare System	53
2.5.2 Racism in Canadian Nursing	56
2.6 The Experiences of Racialized Nurses in Canada.....	58
2.7 The Experiences of Muslim Nurses who Wear a Hijab.....	61
Chapter 3: Theoretical Positioning.....	64
3.1 Introduction	64

3.2 Critical Race Feminism	65
3.2.1 Anti-Essentialism	69
3.2.2 Intersectionality	71
3.3 Care Ethics.....	76
3.3.1 Intersectionality and Care Ethics.....	84
Chapter 4: Methodology.....	87
4.1 Introduction	87
4.2 Narrative Inquiry	87
4.3 Sampling and Participant Recruitment.....	91
4.3.1 Sample Size	91
4.3.2 Participant Recruitment	92
4.4 Data Generation	96
4.5 Data Analysis	98
4.5.1 Intersectionality as an Analytic Lens.....	99
4.6 Trustworthiness	102
Chapter 5: Counter-Narrative: Muslim Nurses Speak Up.....	105
5.1 Introduction	105
5.2 Composite Narratives	106
5.2.1 First Composite Narrative: This is who I am: A Muslim Nurse Who Wears the Hijab and Speaks with a Non-Native Accent.....	108
5.2.2 Second Composite Narrative: I Know What is at Play: Unveiling Operating Power Structures and Power Relations	121
5.2.3 Third Composite Narrative: My Story: Navigating Power Structures and Power Relations	133
Chapter 6: Limitations and Implications	145
6.1 Introduction	145
6.2 Limitations of the Study	145
6.3 Implications for Future Research, Practice, Policy, and Education.....	148
6.3.1 Implications for Future Research.....	149
6.3.2 Implications for Practice and Policy.....	150
6.3.3 Implications for Nursing Education	153
6.4 Concluding Remarks	155
References.....	157

Appendices.....	188
Appendix A. Questions for Screening Potential Participants	189
Appendix B. Recruitment Letter.....	190
Appendix C. Recruitment Poster	191
Appendix D. Participant Consent Form	192
Appendix E. Interview Questions Guide	195

List of Figures

FIGURE 1: The Application of Critical Theoretical Approaches

96

List of Tables

TABLE 1: Composite Narratives

119

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Dedication

This study is dedicated to my family. To my husband and children who provided me with unconditional love and support. I truly could not have completed this work without you all in my life. My love and thanks for my two beautiful daughters who never veered from cheering for me, who always gave me the time and the space to have meaningful conversations that added richness and complexities to mealtimes and to our car drives. My gratitude to my three sons who are growing up to be responsible, gentle, and considerate young men: I am proud of you.

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Chapter 1: Situating the Study

1.1 Introduction

This dissertation is the culmination of an exciting path in my doctoral studies: exploring the experiences of Muslim nurses wearing a hijab¹ and practicing within the Canadian healthcare system, with a focus on examining their social locations that are produced by the intersections of their gendered, racial, and religious identities and how they shape their experiences with anti-Muslim racism. The experiences of the nurses facilitate critical examination and interrogation of the multiple levels of power relations creating and sustaining their social locations and the understanding of the ways in which historical, political, institutional contexts continue to perpetuate anti-Muslim racism. This exploration of the experiences of ten nurses who wear a hijab is informed by critical race feminist theory (CRF) and care ethics. This study is also guided by narrative inquiry as a research methodology. To contextualize the experiences of Muslim nurses who wear a hijab, I situate these experiences within a conceptualization of Islamophobia and, more specifically, gendered Islamophobia, as a form of anti-Muslim racism that is often experienced by women and girls who are identifiable as Muslims. I also locate this study within my own story as a Canadian Muslim nurse who wears a hijab. At the end of this chapter, I provide an overview of the purpose and objectives of this research study and a breakdown of its structure.

1.2 Islamophobia

Despite the understanding that religion plays an equally integral role as an identity of difference, alongside gender, race, and class, the intersection of religion has not yet been

¹ I draw on Droogsma's (2007) use 'hijab', 'veil', and 'headscarf' interchangeably to refer to various forms of head coverings adopted by Muslim women that covers most of a woman's head, ears, arms, and neck. I also acknowledge that though wearing the hijab is an integral aspect of the Muslim identity that is held by Muslim women, its forms continue to evolve and change from one generation to another and between different regions (Bhowon & Bundhoo, 2016).

explored in depth within CRF and intersectionality (Antunes, 2017). As shown in Reimer-Kirkham and Sharma's (2011), as adopted from Woodhead (2008), religion is conceptualized as

[...] a name we give to a complex set of social practices which structure individual agency, and are in turn recursively structured by it. At the heart of these practices there is a collective articulation and celebration of the sacred, which is experienced as transcending the everyday world. Religions seek to embody the sacred-transcendent not only by way of sacred objects, buildings and spaces, but in their collective lives (p. 55).

Thus, religion functions as a source of individual and group identity. It is as a symbol of difference that "infers colonial images of the racialized Other, so as to position those who are not White Christians on the margins and thus reinscribe long-standing patterns of exclusion and inclusion" (Reimer-Kirkham & Sharma, 2011, p. 115). Reimer-Kirkham and Sharma contend that examining religion within intersectionality aids in the understanding of religion as an interlocking system of oppression and of its racialization since 9/11. It also addresses the increasing number of calls upon intersectionality researchers to move beyond the study of race, gender, and class trinity and to include other dimensions of inequality as religion (Mahmood, 2005; Singh, 2015; Weber, 2015). This scarcity of the examination of religion within intersectionality is surprising considering the significant role religion plays in the lives of many women and the role of intersectionality as the branch of feminist thought that attends to the identities of difference and their intersections (Singh, 2015). Indeed, religion has not been extensively considered within intersectionality despite the role religion occupies as an identifier, which complicates the intersections of gender and race. Thus, religion cannot be ignored or dismissed as an important identity marker.

In the aftermath of the terror attacks on September 11, 2001 (9/11) there has been an alarming rise in Islamophobia across the globe (Shaheed, 2021). Here, I draw on Said's (1978) critique of Orientalism and situate it within the context of settler colonialism to critically examine Islamophobia, its roots and how it functions. Said describes a system of knowledge within the West about the 'Orient' that is based on the creation of an artificial binary of 'West/Occident' and 'East/Orient' and holds a dichotomy of 'us and them'. This system goes beyond the geographical divides to extend to ontological and epistemological differences. According to Said, the discourse on the Orient as the 'Other'² is negatively constructed as backward, lazy, violent, oppressive, but also exotic, lustful, and mysterious. Such imaginary construction of the Orient is countered by an image of the Occident as modern, responsible, reasonable, rational, and thus superior.

In his seminal work, Said (1978) convincingly argues that the wielding of power through manipulating differences is at the heart of Orientalism.

[Orientalism] is an elaboration not only of a basic geographical distinction (the world is made of two halves, Orient and Occident) but also of a whole series of 'interests' which, by such means as scholarly discovery, philological analysis, landscape and sociological description, it not only creates but also maintains; it is, rather than expresses, a certain *will* or *intention* to understand, in some cases to control, manipulate, even to incorporate, what is manifestly different (or alternative and novel) world; it is, above all, a discourse that is by no means in direct, corresponding

² Othering is a key concept within postcolonial discourses and in the critical analyses of racism (Thomas-Olalde & Velho, 2011). It is a process employed by those in power who position themselves as superior in relation to those whom they subjugate, colonize, marginalize, and exclude based on assigning imagined negative attributes and characteristics to them (Dervin, 2015; Thomas-Olalde & Velho, 2011). Therefore, fundamental to the process of Othering is the binary of 'us' and 'them'.

relationship with political power in the raw, but rather is produced and exists in an uneven exchange with power political (as with a colonial or imperial establishment), power intellectual (as with reigning sciences like linguistics or anatomy, or any of the modern policy sciences), power cultural (as with orthodoxies and canons of taste, texts, and values), power moral (as with ideas about what ‘we’ do and what ‘they’ cannot do or understand as ‘we’ do) (p. 12).

The theme threaded throughout the elements of Orientalism is the relationship between power and knowledge production in which knowledge is employed to serve the interests of the West by creating the image of the ‘Orient’ as both different from and inferior to (Devadoss & Culcasi, 2020). Therefore, Orientalism is “a Western style for dominating, restructuring, and having authority over the Orient” (Said, 1978, p.11). In this sense, Said’s thesis intertwines with settler colonialism³ in that it is founded upon logics and structures that promote White privilege and supremacy (Devadoss & Culcasi, 2020).

Importantly, Said’s (1978) Orientalism critiques the essentializing Western discourses about the so-called East, the geographical territory including Asia, North Africa, and the Middle East, which was largely colonized by Europe until the mid-Nineteenth century. Though Said speaks to how the construction of the Orient serves as a tool of colonialism, as he argues, Orientalism is a tool of Western domination to justify colonization through dehumanizing the ‘Other’ to exploit their land, labor, and resources. Similarly, settler colonialism uses the same logic by painting Indigenous peoples as inferior and savages to eliminate and displace them and to acquire their lands. Indeed, as articulated by Wolfe (2006) in his seminal paper, settler colonialism is a distinct formation of colonialism that operates along similar logics.

³ Settler colonialism is further discussed in the next chapter

Settler colonialism is described by Coulthard (2014) as “a particular form of domination”, where power in the form of “interrelated discursive and nondiscursive facets of economic, gendered, racial, and state power - has been structured into a relatively secure or sedimented set of hierarchical social relations” (p. 6-7). I agree with the argument laid by Devadoss and Culcasi (2020) that the interconnectedness between settler colonialism and Orientalism is evidenced in the Othering of racialized people who though were not subjected to the early colonial settler practices, Orientalist-settler colonialism impacts every aspect of their lives, and they are exposed to similar practices and discourses that are maintained through the centrality of Whiteness in defining the national identity.

Despite four decades passing since this original work was written, the notion of Orientalism remains a deep-rooted episteme of Westerners about the Orient that has been central to the colonial project. In this vein, the notion of Orientalism is not about the ‘Orient’ but is merely about how Westerners and Western scholars paint a contrasting and mythical image of the Orient, positioning the Orient at the periphery while they maintain their central and powerful geographical and cultural position. Orientalism, therefore, holds several implications in that it is based on striking ontological and epistemological differences between the Orient and the Occident and demonstrates the assumed dominance of the powerful West and its oppression of the weak East (Wang, 1997).

The Orientalist colonial discourse continues to operate in reducing complex identities and practices into simple monolithic explanations, which is seen, for example, within the discourses on Muslims and on the hijab and Muslim women who wear it. Despite their vast diversity, Muslims are frequently grouped together in a singular monolithic representation as possessing qualities and characteristics that render them barbaric and violent (Perry, 2015). Islam is often equated in Western political discourses and in the media with terrorism and

Muslims with terrorists who are antithetical to the civilized West and its modern values. This conceptualization of Islam and Muslims, as Bakali (2016) argues, is how Islamophobia is employed as a political tool to generate fear of and hatred towards Muslims. Hence, Islamophobia can be linked to the discourse on the Orient through the persistent colonial images of Muslims that have been used to create and sustain it (Hoodfar, 2003).

Though there is no doubt that many acts of terror and violence have been committed under the name of religious teaching and doctrine, including Islam, attention is centered on violence committed by Muslims and enacted in Muslim countries (Harpci, 2021). For example, since the 9/11 terror attacks, the media and the state have continued their focus on Muslim violent extremists and the role of Islam in radicalizing people while very little concern has been directed to Christian fundamentalists and right-wing extremists who use religion to promote violence among their followers (Harpci, 2021). Critically examining what underpins this discourse enriches our understanding of Islamophobia as it is rooted in the tendency to essentialize Muslims and in generalizing all Muslims as violent and terrorists. Indeed, the essentializing of Muslims fits within the two coexisting narratives that “all terrorists are Muslim,” which morphs at times into “all Muslims are terrorists” and that “White people are never terrorists” (Corbin, 2017, p. 457). As the Canadian Pakistani Muslim feminist Shaista Patel (2015) rightly argues “this labeling of Muslim bodies as terrorists was the legacy of a White-supremacist settler-colonial governmentality that continues to label Indigenous peoples of this land as terrorists and then targets them for disappearance and death” (p. 9). Islamophobia, therefore, is a White settler colonial state project, where 9/11 and “its aftermath are not exceptional but are in fact the legacy and continuation of the historical violence of the settler-colonial nation-state” (Cahill, 2019, p. 358).

Islamophobia is the “backbone of anti-Muslim racism”⁴ (Massoumi et al., 2017, p. 8), and “shares the same logic as racism because it essentializes a constructed group of people as having inherent qualities that cast them as inferior” (Moosavi, 2015, p. 654). This group of people are those who are also constructed as racially different/inferior, including ‘swarthy’ Arabs, Black, brown and oriental people who make up the majority of those who identify as Muslims in which their Muslim identity is also transferred to a racial identity. Further, both Islamophobia and anti-Muslim racism refer to the formation of an ideology that is built on a fixed set of beliefs, metaphors, and analyses that inform governmental and institutional policies, social discourses, beliefs, and practices that normalize anti-Muslim biases (Sheehi, 2011). Beydoun (2016) contends that Islamophobia is

[...] the presumption that Islam is inherently violent, alien, and inassimilable.

Combined with this is the belief that expressions of Muslim identity are correlative with a propensity for terrorism ... Islamophobia is rooted in understandings of Islam as civilization's antithesis and perpetuated by government structures and private citizens ... Islamophobia is also a process- namely, the dialectic by which state policies targeting Muslims endorse prevailing stereotypes and, in turn, embolden private animus toward Muslim subjects. Islamophobia therefore has three dimensions: structural policy, private animus, and the dialectical process by which the former legitimizes and mobilizes the latent and patent bigotry of individuals and private actors (p. 2).

Beydoun’s definition of Islamophobia extends beyond the Othering of Muslims and associating them with negative attributes to include a structural form of Islamophobia and a

⁴ In line with this statement, throughout this study, I use the terms Islamophobia and anti-Muslim racism interchangeably.

‘dialectical process’ that shape the perceptions of Islam and Muslims among private citizens while legitimizing governmental policies and legislations that disproportionately target Muslims. Therefore, jeopardizing their civil liberties and human rights.

Islamophobia is becoming more evident globally (Poynting & Perry, 2007), in the United States (US) (Selod & Embrick, 2013), and in Canada (Al-Qazzaz, 2020; Helly, 2004; Poynting & Perry, 2007). It is reportedly fueled by the ongoing Syrian refugee crisis and the terror attacks on major European cities, including Paris, London, and Brussels, and most recently by associating Muslims with the COVID-19 pandemic and blaming them for spreading the virus (Al-Qazzaz, 2020). It is sustained by the continuing political rhetoric, the intense media attention on Muslims and the role it has in shaping public attitudes (Calfano et al., 2017; Perry & Poynting, 2006), and by linking the threat of terrorism to immigration and refugee policies (Thobani, 2018). For example, the Anti-Terrorism Act/Bill C-36 in Canada (Perry & Poynting, 2006), the Anti-Terrorism Act (2001 and 2015), the National Security Act (2017) and the Immigration and Refugee Protection Act (2001) include measures that expand the powers of the state, while lacking transparency and oversight, to strip fundamental human rights away from Muslims, and create spaces where laws are suspended (Razack, 2008). A glaring example is seen in the terrorism peace bonds that were originally created in 2001 as pre-emptive measure to stop suspected or imaginary terrorists, where detention is granted to police forces by judicial authorities if they demonstrate that a person *will* commit a terror attack while there is a lack of evidence to charge with a crime (Ahmad & Monaghan, 2020). This burden of proof was further adjusted in 2015 to demonstrating that a person *may* commit an act of terrorism, which reflects a move from “probabilities to possibilities”, where the ‘possibilities’ are filtered through racist and Orientalist constructions of Muslims and Islam. (Ahmad & Monaghan, 2020, p. 342). Ahmad and Monaghan argue that though the bonds have

not received much public and legal scrutiny, they have normalized racialized and pre-emptive security practices and have moved the Canadian criminal law from “a domain of protection against state intrusion to one of extending policing power” (p. 342). Islamophobia is also reinforced by the ban on the hijab as a religious symbol (seen recently in Quebec for public sector employees while at work) that signifies oppression and threatens the Western values of freedom and the commitment to advancing women’s rights (Bilge, 2010; Bullock & Jafri, 2000; Khiabany & Williamson, 2008).

1.2.1 Gendered Islamophobia

Alimahomed-Wilson (2020) maintains that “[t]he conceptualization of Islamophobia as a gender-neutral form of racism underestimates the centrality of gender as an ongoing, co-constitutive axis of power that structures Islamophobia” (p. 649). It is no surprise then that gender and gender-based discrimination continue to be a central thesis to the colonial project, as they are often ideologically weaponized by the state and the media apparatus who manufacture gendered Islamophobia to provide the rationale for dehumanizing Muslims, portraying them as foreign and ‘not belonging’ (Alimahomed-Wilson, 2020; Fernandez, 2009; Nagra, 2017), and normalizing their oppression at the interpersonal, institutional, and disciplinary realms (Alimahomed-Wilson, 2020). Therefore, in this section I am arguing that anti-Muslim racism has been informed by the colonial project within the framing of concerns for Muslim women and their oppressed state⁵ with an acute focus on gender-based practices, mainly on the practice of

⁵ Although in this study I focus on women’s experiences of Islamophobia, men experience Islamophobia as well (Alimahomed-Wilson, 2020). Muslim men, too, are oppressed within the colonial narrative about Muslims where race and/or religion are central to their experiences in relation to gender. Gender as a power structure that shapes Muslim women and men’s experiences differently, as some axes and identities may be more pertinent to a specific social context or outcome than others. Therefore, Muslim women’s experiences of Islamophobia are essentially different than those of Muslim men.

veiling (Wagner et al., 2012). The pursuit to save Muslim women from the control of Islam and Muslim men has been used to disguise the racist binaries of good and bad, modernized and barbaric, and freed and oppressed, which have continued to inform the discourse on Muslim women in the West (Fernandez, 2009).

‘Gendered Islamophobia’, a term coined by Canadian sociologist Zine (2006) to refer to “specific forms of ethno-religious and racialized discrimination leveled at Muslim women that proceed from historically contextualized negative stereotypes that inform individual and systemic forms of oppression” (p. 240). The veil has become a powerful symbol of cultural, religious, and political differences between Muslims and non-Muslims (Haddad, 2007). The constructed master-narratives about the veiled woman as unfree and in need of saving and as an agency-less victim of her religion has been employed to push forward the narratives on the superiority of Western values (Thobani, 2007, 2018). Such narratives reproduce the colonial discourses, while positioning Western voices as the authority to speak for Muslim women and to carry the banner of freeing them. Indeed, a critical examination of the discourses on the veil and veiled women fits within Spivak's (1988) critique of postcolonial studies that homogenize the subalterns⁶, illuminate their differences from the powerful and the privileged while assuming the authority of ‘speaking for’ the subaltern, and thus, obliterating their voices to speak for themselves.

The hijab also has become a representative of the terrorist living ‘among us’. This representation of the hijab exposes women who wear it to a large degree of vulnerability to anti-

⁶ In her seminal essay ‘*Can the Subaltern Speak*’, Spivak (1988) borrowed the term ‘the subaltern’ from the Italian Marxist Antonio Gramsci to point to colonial subjects who are socially, politically, and geographically excluded from the hierarchy of power, deemed inferior and are deprived from the right to speak for themselves. “If, in the context of colonial production, the subaltern has no history and cannot speak, the subaltern as female is ever more deeply in shadow” (Spivak, 1988, p. 287).

Muslim racism and violence (Aziz, 2012; Chakraborti & Zempi, 2012; Hammer, 2013; Perry, 2014). The gendered nature of Islamophobia is an example of the ways in which racism and sexism build on one another where the two systems of oppression intersect to affect Muslim women in distinct ways from how Islamophobia affects Muslim men, and from how sexism affects non-Muslim women (Riley, 2011, p. 5). These affects cannot be understood as simply the totality of the effects of Islamophobia and sexism. Indeed, a woman who wears the hijab does not face one-dimensional discrimination as a woman or as a practicing Muslim. Rather, she experiences intersectional discrimination unique to a ‘Muslim woman who is wearing a hijab’.

Indeed, while anti-Muslim policies and practices by the state have mushroomed since 9/11 (Poynting & Perry, 2007, p. 151), those who are identifiable as Muslim, mainly the highly visible Muslim women wearing hijab, are more likely to be subjected to them (Dana et al., 2018; Poynting & Perry, 2007). This hypervisibility to the public gaze “creates a paradox: women wearing hijab are surveilled everywhere” while their voices are silenced (Antunes, 2017, p. 108). By connecting the hijab to “hostility to democracy and the fear of fundamentalism, the language of violence weaves its way into the very fabric of the hijab” (Fernandez, 2009, p. 284). Fernandez warns that beginning from an assumption that such coercion exists by normalizing this constructed discourse on Muslim women wearing the hijab creates a framework that manufactures and sustains oppression and violence towards them.

It is widely reported that the events of 9/11 heightened the gaze on Muslims and, more acutely, on Muslim women who veil, invigorating the Orientalist views on the veil as a signifier of oppression and foreignness, and as a symbol of suspicion and violence (Aziz, 2012; Khalid, 2011, Poynting & Perry, 2007). Recently, the COVID-19 pandemic has further perpetuated racial stereotypes wherein Asian and Muslim communities have seen significant increases in being targets of hate crimes in Canada (Al-Qazzaz, 2020; Lee & Johnstone,

2021). As the virus originated in China, the virus as 'danger' was projected on Asian bodies, which made them a target for discrimination and violence (Lee & Johnstone, 2021). This projection and discrimination expanded to especially racialized bodies that were labelled as a risk for spreading the virus, apparent in the rise of Islamophobia online and in the media, and in the increase in harassment and physical violence against Muslims who have been blamed for of the COVID-19 pandemic and labeled as super spreaders of the coronavirus, culminating in the increase in violence targeting Muslim women who wear a hijab (Al-Qazzaz, 2020). This propensity to target and victimise Muslim women is, again, witnessed in the midst of the COVID-19 pandemic in the many stories of attacks on Muslim women in multiple Canadian cities (Al-Qazzaz, 2020), and in the premeditated killing of four members of a Muslim family in London, Ontario because of their religion (both parents, their daughter, and her grandmother were killed, also leaving their nine year old son critically injured) when a truck driver slammed into them while the family was on an afternoon walk (Riess & Lemos, 2021).

1.3 My Story

By virtue of wearing a hijab, I carry my Muslim identity with me every time I walk into a patient's room or interact with a family member. I believe this identity shapes people's perceptions of me as a nurse and takes precedence over my professional nursing identity. It also defines most of my interactions with patients and members of the public and increases the likelihood that I will feel the hurtful sting of racism. Many times, I am reminded-through someone's casual comment, a momentary stare or an intentional Othering ... statement - that I am different and that I do not belong (Saleh, 2017, p. 34).

This personal testimony captures an essential aspect of my experience as a racialized woman, which is inseparable from my experiences as a nurse who wears a hijab. Though not all my experiences are of a negative nature, I am often reminded of my differences, differences that

I have embraced. I am, at times, singled out and asked by patients and other nurses about who I am or what I am doing as if it is surprising that I could be a nurse. I was recently stopped before entering a patient room and ordered me to 'stay out' because, in the words of my patient, she told me she did not like people who look like me while circling her hand around her face in reference to my hijab. I also remember being told by a manager who interviewed me for a position that she only saw my hijab at the beginning of the interview and how at the end of the interview, she came to see me as a nurse. These are a few examples that capture some of the statements and actions that I so often experience. At times, I shrug them off and go about caring for my patients. At other times, I am surprised at the degree of my vulnerability and at the hurt and anger I feel when I am casually addressed by dismissive, racial, or discriminatory remarks.

My first experiences with Othering within nursing were during my clinical placements as a student. Most of these experiences were subtle and I was usually left with a feeling of unease or with lingering uncertainty regarding the nature of what I experienced. From eye rolling to heads turning away, to being treated like I was invisible; it is indeed mannerisms and body language that are most difficult to interpret. In the beginning, there was always an innocent explanation that I leaned on to mitigate the sting of such actions. In the face of these experiences emerged a subtle, but prevalent need to strive for perfection, to not make mistakes. Though I was a student and needed to make mistakes to learn, I was in fear of having them held over me as evidence of my incompetence as a Muslim nurse in training.

When discrimination was directed at me by patients, often it was blunter, and therefore, easier to recognize. Patients, unlike my nursing colleagues, can refuse to have me care for them and blatantly ask me to leave their rooms. At times, actions that are based in good intentions result in similar, if not equal outcomes as those that are meant to dehumanize and exclude. I

clearly remember an encounter at the end of a clinical practice day in which I stood at the entrance of the hospital waiting to be picked up when another hospital employee crossed the road and walked straight towards me with an open hand to shake mine. He said: "I saw you and I wanted to tell you that I welcome you into my country" and he walked away. I was left speechless. I stood at the same spot with my thoughts racing so quickly that I did not see my ride pull in front of me. There I was with my nursing uniform, my student ID clipped on, and my hijab. Yet, the significance of my uniform and ID were overshadowed by my hijab. My hijab communicated to this employee my assumed foreign status and my outsider presence. Canada, in that brief moment, was not my country, it was his and he was happy to welcome me in it. Though, on the surface, this action relayed a positive attitude, on a deeper level, it served to remind me of my differences and reinforce my Otherness.

Outside of the walls of the hospital and my practice as a nurse, I have experienced my share of blatant racism. Once I was driving on the highway with a friend on a nice sunny afternoon when a group of young men drove fast past us and threw an open beer can at my car. I heard them yell something that I did not catch. My friend refused to tell me what she heard. On another day and another time, I was pushing my shopping cart and walking aimlessly between the aisles of a large department store when a man walking with a woman cut me off and muttered "stupid, why don't you go back to your country". Such incidents are not only a reflection of male aggression, I have also had similar comments from women who have made direct and racially loaded remarks towards me. I am sharing these examples knowing that I ought to share my story as a nurse. But my story as a nurse who veils does not take place in a vacuum. My story is formed against the Canadian context that fosters an environment for such actions to persist through the circulating discourses and the imagined representations of Islam and Muslim women

who wear a hijab. When I put on my nursing uniform, when I walk through the doors of a hospital, a ward, a patient room, I am still under the gaze of the public, and I am within the public sphere that remains mostly unwelcoming towards Muslim women who veil. It is a realization that I am not immune to the stereotypes and assumptions about women who wear a hijab because I simply replace 'woman' with 'nurse'. Indeed, my gendered, racial, and religious identities have continued to shape my experiences as a nurse.

As I am writing my story, I am reflecting on how naïve I was at the beginning of my nursing journey. I truly believed that belonging to such a noble profession meant that as nurses, as healthcare professionals, we can isolate ourselves from societal ills so they will not tarnish us. I was clueless then as to how widespread racism is within the discipline of nursing. Even when I first experienced racist actions or statements, I could not see them within the racial meanings they held. I was not taught about racism in nursing during my undergraduate nursing education. Instead, I became very familiar with the core values of nursing, I was immersed in cultural competencies and in how to care for culturally diverse and Indigenous patients, all which communicated the assumptions that, as nurses, we are to care for everyone equally, that we transcend skin color, ethnicity, gender, religion and so on.

My story will not capture the extent of my experiences as a nurse if I do not talk about infection prevention and control practices and how they were operationalized to cast me as an outsider and to label my hijab as unsafe and unclean. When I was a student, a nurse leader approached me and requested that I roll up my sleeves above my elbows because they acted as a vehicle that transmitted infectious agents to patients. When I told her that I will not be able to because it is a part of the religious practice of veiling, she replied "no nurse manager will hire you while you dress like this". Evidently, her articulation of my hiring potential was not based on

my qualifications, skills, or competence. According to this nurse leader, the determining factor that would prevent me from ever gaining employment was my hijab. I understood the embedded message within this interaction, but I was nevertheless upset at being told that I am an unemployable nursing student due to my hijab. Effectively, I was told that my hijab was standing in the way of my ability to be a nurse. Importantly, concerns regarding infection control and prevention such as this one serves to further Othering women who wear a hijab.

I have been explicitly discriminated against in the multiple times I have been called a terrorist. The first time this happened, a patient yelled out the expletive “terrorist” as loud as she could in the middle of the hallway across from the rooms of other patients and by the nursing station where my colleagues stood. Though I was emotionally distraught by the experience and could not stop crying, I stubbornly refused to go home. Indeed, some of my colleagues apologized to me for what happened. I was also told by another nurse that I should not take this patient seriously, as she was “mentally unstable”. The fact remained that I was accused of being a terrorist because I am a Muslim nurse. In that moment, the complex and intricate attributes of my character and personhood were completely reduced to one identity marker. To that patient, I was no more than a Muslim terrorist. My hijab stripped away my Canadian citizenship and rendered me a dangerous woman, a traitor, and with that came my doubted, untrusted image as a nurse. How many patients and how many people have thought of me in the same way this patient did but could not or did not vocalize their thoughts? These were the questions I grappled with as I processed my experience and tried to make some sense of it. This moment was critical to the trajectory of my doctoral studies; it was then when I knew that I would change the substantive area of my research to focus on understanding the experiences of Canadian nurses who wear a hijab. In making this change, I chose to draw on my positions as a Muslim woman, as nurse who

wears a hijab, and as a doctoral student to shine light on our unique experiences. Against the backdrop of the essentialist, colonial, and racist narrative on Muslim women who wear a hijab, my intention is also to showcase the experiences of nurses who wear the hijab and uplift their voices.

I would like to share the story of how I began to wear a hijab and what it means to me. I come from a long line of Palestinians but, due to the continued occupation, I grew up in Riyadh, Saudi Arabia where veiling is mandatory for women. As a result, growing up, veiling was a common and normal practice. However, it was a forced one. Every summer when my family and I would leave the country, I folded my *Abaya*⁷ away and did not veil. When I moved to the US years prior to 9/11, there was no *Abaya* to put away for the summer; I was completely divorced from the practice of veiling. However, years later, I decided to wear the hijab again. After spending months reminiscing on whether I would choose to veil moving forward, I decided that, simply, I needed to wear it. I felt an emptiness within me, a hollow, vacant feeling that working, shopping, visiting with friends, and rearing my children could not fill. I knew I needed to feel more connected to my faith and to Allah. I wanted to reclaim my Muslim identity. Today, the hijab holds more meanings for me. Though it continues to offer spiritual connections, I do not only wear a hijab because I believe I have a duty to do so. Instead, I wear it because I can and because I want to. I now have the freedom of choice to veil, and it is a choice I make every day. Though it has become a part of who I am, it does not define me. I am the same woman, nurse, and person with or without it. And though it continues to shape my story, the hijab itself does not change who I am.

⁷ The *Abaya* is a traditional black robe and a headscarf worn mainly by women in the Arabian Gulf region as a part of their Islamic veiling customs.

Throughout my journey as a nurse who veils, I held different positions and practiced in varied settings. While I have had wonderful experiences and met amazing people, I have also felt estranged in the workplace, sometimes feeling like the office space is not large enough with me in it. Through my work on this study, I was able to understand the forces at play. As a racialized nurse, I am invading White spaces that were not created for me or with me in mind. I do not belong. I am meant to remain outside the borders of spaces that cater predominantly to White nurses, and I am frequently made to feel alien in them. These feelings resurface when I walk into unfamiliar spaces, when I am the new nurse, and, unsurprisingly, when I am the only nurse with a hijab. Such feelings acutely surfaced when, on one occasion, I began a new position and approached a neighbouring nursing office in the middle of my ward in search of my co-worker. Not having found them, I was about to walk away when another nurse called after me. She said, “Get out of there, what are you doing here?” This nurse did not mean to communicate that I was not to enter the office. She was saying that I did not belong in the ward because I could not be a nurse. Again, dressed in my nursing uniform with my ID clipped on and wearing my hijab, I was made to feel as an outsider. I held up my ID and said, “I am a nurse; I work at the other end”. I was met with a disgruntled affirmation and that was the end of it. While this nurse moved on, I was left pondering on the ways she enacted her innate privilege to ensure that I am aware of my outsider status. Though the interaction lasted no more than a few seconds, it stripped the excitement I had for my new position and has stayed with me since.

The privilege and power that are exerted over me as a nurse who wears a hijab can be explicitly seen in an interaction I had with a European patient. While caring for this patient, he told me to get on the same boat that brought me to Canada and to go back home. Though he was also an immigrant from Europe, he was emboldened by my racialization as a Muslim woman and

the de-racialization of Europeans to be able to use his privilege and power over me. This contradiction made me consider the normalization of his statehood against the forces that continue to 'Other' Muslim women. What gives this patient the right to tell me to go 'home'? What makes him a Canadian who can claim his citizenship as an immigrant while taking that same right away from me? This patient was never constructed as a foreigner nor as an outsider, likely a result of his Whiteness and European accent not being deemed unwanted or threatening. He embodied the visual appearance associated with White Canada. Nonetheless, as an immigrant, he was perpetuating negative stereotypes about another immigrant. Sadly, our differences overshadowed our similarities.

This study takes place against my story. I am aware of the inherent subjectivity this positioning holds and I understand the importance of sharing my story and of positioning myself. As an insider researcher who shares similar experiences as the research participants, I hope to strengthen our voices and for this study to be a vehicle from which we move toward enacting social transformation within nursing and beyond. More to the point, my positionality necessitated that I, as a researcher, engaged in reflexivity through continuous self-examination and exploration of how my own experiences, personal biases, and assumptions influenced the research process and my relationship with research participants.

1.4 Reflexivity

Reflexivity has been extensively discussed and analyzed within many disciplines (Dowling, 2006), and is generally defined as "the active process of reflection that researchers using qualitative methods go through so as to document how the research process in general, and often themselves in particular, construct the object of research" (Bolam et al., 2003, p. 2). Reflexivity is both a process and a concept. As a process, reflexivity begins before the beginning

of research by researchers explicitly positioning themselves within their research and critically examining their values and how their positioning influences their perceptions, and how they influence the research (Hesse-Biber & Piatelli, 2007). Hence, Hankivsky and Jordan-Zachery (2019) strongly advocate for reflexivity, calling upon researchers, scholars, and policy makers to, prior to the initiation of the research process, strategically examine their own positionality, their roles, and the powers they hold when taking an intersectional approach to social issues. As a concept, reflexivity is the “introspection on the role of subjectivity in the research process” (Palaganas et al., 2017, p. 427), and it remains open to different interpretations and reconstructions based on varied philosophical and theoretical orientations (Bryant, 2016). However, a main point of agreement among the hundreds of publications on reflexivity is that it is essential to the production of high-quality qualitative research (Dowling, 2006), as the understanding of objectivity has shifted in which Harding (1993) asserts that strong objectivity requires strong reflexivity. Therefore, trustworthiness, or rigour, in qualitative research is linked to credibility (parallel to validity), which is ensured through reflexivity (McCabe & Holmes, 2009). In this vein, subjectivity has been transformed from a problem into an opportunity, and where researchers no longer question the need for reflexivity but rather ask how to go about doing reflexivity in research (Finlay, 2003, p. 5).

Reflexivity is not only a measure or a reflection of credibility, but also a mechanism to inform the researcher and the research process (McCabe & Holmes, 2009), and is a tool to gain new depth in research and to know more about oneself (England, 1994). It is through reflexivity that researchers acknowledge the change in themselves as a result of their research (Palaganas et al., 2017). Reflexivity entails that researchers continually turn the gaze on themselves to understand and to make explicit how their values, assumptions, and social location affect the

research process and their relationship with research participants. Indeed, to be reflexive requires that the researcher has an ongoing internal conversation related to two important questions: what do I know? And how do I know it? (Swaminathan & Mulvihill, 2017). Attending to these questions requires that researchers develop sensitivity to and an understanding of the social contexts they are embedded in. Therefore, the “researcher’s positionality/ies does not exist independently of the research process nor does it completely determine the latter. Instead, this must be seen as a dialogue – challenging perspectives and assumptions both about the social world and of the researcher him/herself” (Palaganas et al., 2017, p. 427).

Throughout the research process, I engaged in reflexivity, which I started before the beginning of the research process to locate myself within my research and within the relationships with the nurses (Merriam & Tisdell, 2016). Through reflexivity, I explicitly position myself within my research and consciously examine how my positioning influences the process from beginning to end. By being reflexive, I became aware of the assumptions I brought into the research. For example, a priori notions of racialized, gendered experiences of nurses who wear a hijab in Canada informed my assumption that the nurses have experienced racism based on the intersections of these identities. I also needed to account for how the social, cultural, and historical factors shape my interpretations and meaning making. Hence, an approach to doing reflexivity that I adopted was keeping a research journal to practice self-disclosure of my own assumptions, beliefs, values, and emotions. Keeping a journal ensured that I maintained a track or a record of theoretical perspectives, beliefs, assumptions (Creswell & Miller, 2000) and different experienced emotions that might have shaped the inquiry. When I began the interviewing process, I attended to the three types of reflections cited in Adam (2013): 1) reflection in-action, which were entries related to the interviews; 2) reflection on-action, which

were entries after the completion of each interview that capture similarities and differences between research participants and myself; and 3) reflection through-action, which were carried when making decision about analyzing and interpreting data and arriving at the findings. To arrive at the findings of the study, I made transparent decisions about my methodology, recruitment strategy, and steps to analyse the stories.

Feminists and critical race researchers have used reflexivity as a means to account for the researcher's privilege and power (Dowling, 2006; Harding, 1991). Reflexivity from a critical feminist standpoint addresses the issue of unexamined power imbalances between the researcher and research participants within the different stages of the research process by examining how gender-based differences influence and shape the research process (Hesse-Biber & Piatelli, 2007). As McCabe and Holmes (2009) contend, critical research that is directed towards transformational change is political in nature, and thus, presents challenges to the researcher, participants, and to the research process. Hence, reflexivity entails more than ensuring the credibility of research by controlling the effect of the researchers on the research process; it is a tool that can be used to empower both individuals and groups through acquiring knowledge and gaining new insights and perspectives (McCabe & Holmes, 2009). However, reflexivity alone does not remove the unbalanced powers but doing reflexivity throughout the research process heightens power imbalances in the relationship between researchers and participants, "exposing the partiality" of researchers' perspective (England, 1994, p. 250). Pillow (2003) adds doing reflexivity within a critical feminist paradigm aims to ensure that researchers are compassionate and "non-exploitative" by attending to the negative effects of power imbalances between the researcher and participants, and that being reflexive extends beyond examining powers rooted within the research but also to do research differently (p. 178). In this study, reflexivity served to

account for my own privilege and power (Dowling, 2006; Harding, 1991). Reflexivity demands that as a researcher, I locate myself and critically examine how my locationality has influenced the research process. Reflexivity meant that I was attentive to power imbalances embedded in my role as a researcher and a doctoral student and the privileges these roles hold. To do research differently, I was committed to developing reciprocity with the participants by actively listening to them, answering their questions, and striving to attain and maintain an equal relationship. Reflexivity is used to deconstruct the researcher's authority in the process by presenting data in ways that allow the participants to speak for themselves (Pillow, 2003). Here, I believe that by constructing the composite narratives in first person to present and analyse the nurses' stories, the nurses spoke for themselves and presented their experiences as a whole.

A researcher in relation to research participants can be either as an insider who shares their experiences or as an outsider who has no personal familiarity or experience with what is being studied. The researcher also may fall within a fluid continuum transitioning from an outsider to an insider during the course of the research (Berger, 2015). As an insider, the researcher may gain a degree of legitimacy and acceptance by research participants. I am aware of my positioning as an insider who mostly shares similar identities as the participants. Being an insider offers me unique insight into the experiences of the participants and influences my research and my relationship with research participants. My insider positioning allows me to access data that may not be accessed by an outsider, as participants tend to be more receptive and open to share their experiences when they perceive the research as someone who understands their experiences and is sympathetic to them (Dwyer & Buckle, 2009). Alternatively, as an insider, I have preconceived notions and assumptions about the experiences of the participants. Hence, reflexivity is instrumental in highlighting my assumptions and examining how they have

influenced participants' stories and how they were told. As an insider, an inherent risk of which I am aware, is that participants might not have shared certain experiences they perceived as already known to me (Berger, 2015).

I am, in relation to my positioning as a doctoral student and as a researcher, in the eyes of research participants, shifting between being an insider and an outsider. Through reflexivity, I continuously examined how moving between my positioning as an insider and as an outsider influenced my relationships with participants, how it shifted power relations between myself and participants, and how I mitigated such impacts. For example, one main approach to addressing power imbalances between myself and research participants was in creating a space for collaborative dialogue with the goal of establishing mutual understanding (Lather, 1986; 1988), and in revealing some aspects of my own story as a Muslim nurse who wears the hijab, which affirmed my insider status and made interviewing a reciprocal process.

1.5 Research Purpose and Objectives

The purpose of this study is to explore the experiences of Canadian nurses wearing a hijab with Islamophobia. Embedded within this overarching research purpose is the goal to examine the intersections of the gendered, racial, and religious identities of nurses who wear a hijab and how they shape their experiences with anti-Muslim racism, and to interrogate multi-level power relations that operate to produce and maintain the social locations experienced by these nurses.

The main research question is: What are the experiences of Canadian Muslim nurses who wear a hijab and practice within the Canadian healthcare system? This question encompasses three sub-questions:

- 1) How do Muslim nurses' social locations that are produced at the intersections of gender race-religion converge in understanding their experiences as Muslim nurses who wear a hijab?
- 2) What are the power relations enacted within the discipline of Canadian nursing that produce and sustain social locations experienced by nurses who wear a hijab?
- 3) What are the ways these nurses resist their racialization and push against master-narratives that are constructed about them?

The specific objectives of this study are to:

1. Tell the stories⁸ of Canadian nurses who wear a hijab.
2. Examine the intersections of the racialized, gendered, and religious identities of nurses wearing a hijab and how they intersect to shape their experiences with anti-Muslim racism.
3. Provide an account of the historical, political, and social contexts of Canada that lay the grounds for anti-Muslim racism and uncover the existing structures and power dynamics at play that shape the nurses' experiences and continue to maintain the status quo of privilege and oppression.
4. Understand, based on their stories, the ways nurses who wear a hijab claim control over the constructed narrative about them.
5. Inform and transform nursing education, policy, and practice, with the aim of creating and sustaining supportive educational and practice environments for Muslim nurses who

⁸ In this text, I use 'story' and 'narrative' interchangeably to describe personal narratives or stories, for a key aspect of narrative inquiry is "the central place of narrative when personal lives and social institutions intersect" (Riessman, 2008, p. 3).

wear a hijab and for racialized nurses collectively, with the goal of using these stories to advance transformational change in nursing.

1.6 Significance

The heightened debate around Muslim women who veil points to the need for exploring the unique and complex social locations that shape their experiences. Evidence on how women who wear a hijab are stereotyped, discriminated against, and targeted by anti-Muslim racist acts (Aziz, 2012; Chakraborti & Zempi, 2012; Riley, 2011), along with the persistence of racism within Canadian nursing and the experiences of Othering and discrimination by racialized nurses in Canada, including my own experiences, informed my assumption that Canadian nurses who wear a hijab experience anti-Muslim racism in their everyday practice.

This study took place within the unique and challenging contexts of heightened anti-Muslim racism, specifically the rise in Islamophobia, in Canada and the US (the era of Trump and the targeting of Muslims and Muslim countries in US politics), against the background of banning the hijab in the province of Quebec and the ongoing debate this ban continues to generate, and during the COVID-19 pandemic and the recent events of violence directed against visible Muslims, and particularly, Muslim women in Canada. This study also took place against an increased understanding of the ongoing colonial state-building project of Canada and its continued legacy, and the urgent need for transformational change within the healthcare system and beyond (Turpel-Lafond, 2020).

There exists a plethora of research exploring the intersections of axes of difference (e.g., gender, race, and class), and how these intersections shape the experiences of racialized women (Collins, 1993; Crenshaw, 1991; Grillo, 1995; Mohanty, 2003). However, there is limited research examining racism within nursing from the perspective of racialized Muslim

nurses and the social locations produced by the intersections of their gender, race, religion, and other markers of difference. This gap is clear within the Canadian context and becomes even more pronounced in the absence of research on the experiences of nurses wearing a hijab. Shedding light on the experiences of these nurses will fill an existing gap of knowledge and will offer a unique window into the interplay of power structures and power relations that exist on multiple levels to sustain privilege and oppression in nursing and broader healthcare structures.

Critical qualitative research, and mainly research that examines oppressive social structures, focuses on marginalized populations to move towards transformational change and to enact social justice (Cook, 2008; Stanley & Haynes, 2019). However, the population of nurses who veil has been neglected despite their hypervisibility, the surge of anti-racism in Canada, and the gendered racialization of Canadian Muslim women. Taking on this important and timely research also fulfills an ethical responsibility of my role as a nurse within the academy to enhance social justice, to speak against matters such as racism, and to reclaim storytelling to capture inequities (Banks, 2014). Further, this study offers a point of resistance for nurses who wear a hijab to articulate and communicate their counter-narrative and engage in a research agenda that addresses a call to action within nursing toward transformational change (Clark & Saleh, 2019).

This study challenges the silence in the nursing discipline on racism and the denial of its existence by providing a nuanced understanding of power relations within the discipline that privilege some and oppress others. This research also examines the intersection of religion, which is often neglected in intersectional studies (Reimer-Kirkham & Sharma, 2011). Above all, this study captures the diverse voices of Muslim nurses who wear a hijab to resist the reductionist, gendered, and racialized narratives constructed about them. Finally, the study

findings offer insight into the experiences of a group of nurses whose stories are to be used to inform actions and policies with the aim of decolonizing nursing through enacting an anti-racist framework to guide nursing research, policies, practice, and pedagogy.

1.7 Structure of the Dissertation

The conception of this dissertation was first ignited by my own experience as a Muslim nurse who wears a hijab and by a persistent curiosity to explore the experiences of nurses who hold similar, but at the same time distinctive identities. Due to the sensitive nature of the nurses' shared stories and the ease with which their identities might be revealed if their characteristics are shared (i.e., specific geographical locations, educational backgrounds, specific practice sites or specialties), it is important to note that certain identifying information has been withheld or omitted from this dissertation in order to protect the identities of the nurses who participated in this study.

This dissertation is structured as follows:

In chapter one, I situate the study within a definition of Islamophobia and its construction and move to discuss gendered Islamophobia and its relation to Muslim women who veil. To locate myself within this study, I share my story as a Muslim nurse who wears a hijab. I then move to offer an overview of reflexivity as both a concept and a process and its added value to critical feminist research. I end this chapter by introducing the study's purpose, objectives, and significance, and by explaining the structure of the dissertation. My goal in the second chapter is to present the circulating master-narratives about Muslim women and Muslim women and nurses who veil, and to provide a comprehensive account of the contexts against which these experiences are shaped. To arrive at this objective, I discuss the racialization of Canadian Muslims and present an overview of the discourse surrounding the veil. I also locate the experiences of nurses who wear a hijab within the historical and

sociopolitical Canadian context of colonialism, neoliberalism, multiculturalism, and the ban on the use of religious symbols within the public sector in Quebec, which collectively provide the context for the racialization of Canadian Muslims and Muslim women who wear a hijab. I then move to discuss the context of racism within the Canadian healthcare system and in Canadian nursing. To contextualize the experiences of Muslim nurses who wear a hijab, I provide examples from the literature on the experiences of racialized nurses in Canada. In chapter three, I position the study within critical race feminist theory and care ethics, providing an overview of each of the theories and how they collectively inform the framing of this study and the research process. In the fourth chapter, I discuss the research methodology and explain the sampling and recruitment strategy, data generation and data analysis processes that I employed. My goal in chapter five is to present the counter-narrative of nurses who wear a hijab. Therefore, I organize the findings in three composite narratives that convey the experiences of the nurses and analytically discuss each of the composite narratives, grounding the findings within the literature. Finally, in chapter six, I outline the limitations of the study and its implications for future nursing research, practice, policy, and education.

Chapter 2: Master-Narratives

2.1 Introduction

Master-narratives are the "pre-existent sociocultural forms of interpretation. They are meant to delineate and confine the local interpretation strategies and agency constellations in individual subjects as well as in social institutions" (Bamberg, 2004, p. 287). Intrinsicly, master-narratives are dominant discursive agents woven by the dominant culture into the fabric of societal structures to garner and maintain power, while justifying the subjugation of marginalized people and their communities (Giroux, 1991; Stanley, 2007). On the other hand, counter-narratives offer an alternative reality that differs from the reality offered by master-narratives (Delgado, 1989). In this vein, the purpose of counter-narratives is to "reveal the contingency, partiality, and self-serving quality of the stories [master-narratives] on which we have been relying to order our world" (Delgado, 1993, p. 666). Counter-narratives hold a deeper understanding of systemic and institutional racial oppression, and offer an insight into its disruption (Vaught, 2008). Hence, critical race theorists consider the construction of counter-narratives as an act of resistance in that counter-narratives involve "telling the stories of those people whose experiences are not often told" (Solórzano & Yosso, 2009, p.138).

As there is minimal research exploring anti-Muslim racism in nursing through the experiences of Muslim nurses who wear a hijab, I situate this study within the master-narratives about Muslim women who veil and the dominant discourses surrounding the veil. I also explore the border historical and sociopolitical context that has laid the grounds for these master-narratives to continue to support and legitimize anti-Muslim racism within Canada and, more specifically, within Canadian nursing, by examining the interplay of settler colonialism, neoliberalism, multiculturalism, and the Quebec ban of the use of religious symbols. Likewise, I

include a review of writings on racism within Canada's healthcare system and racism within Canadian nursing to offer a critical examination of existing structures and power dynamics that produce and maintain Islamophobia. Finally, I draw on the literature on the experiences of racialized nurses in Canada more broadly to lend another level of nuance that supports the main purpose and the objectives of this study.

2.2 The Racialization of Muslims in Canada

In 2011, the number of Muslims in Canada passed one million, constituting about 3.2% of the population and representing one of the fastest growing religious groups and the second largest religion in the country after Christianity (Enviroics Institute, 2016; Statistics Canada, 2013). Yet, Muslims in Canada are a poorly treated and understood religious minority group who are not as accepted as other religious minorities and are often looked upon with discomfort as a group of immigrants who do not fit within the fabric of Canada (Enviroics Institute, 2016). Unsurprisingly, the Canadian Muslim community has remained underrepresented in Canadian politics and in government services (Mann, 2017). Mann, among others, argues that major Canadian political parties have yet to make any purposeful or coordinated effort to recruit Muslims as party members or candidates in elections. These trends in turn preserve the underrepresentation of Muslims in Canadian politics and government services, leading to further silencing of their voices (Mann, 2017). This unique positioning of Canadian Muslims manufactures ongoing challenges "with respect to religious freedom, acceptance by the broader society and national security profiling" (Enviroics Institute, 2016, p. 1). Challenges that Canadian Muslims face also result from formulated impressions about them that are informed by oversimplified stereotypes and erroneous narratives that infiltrate the public opinion and institutions, which are also enforced and

reproduced by policies and laws targeting Muslims (Enviroics Institute, 2016; McDonough, 2003). Thus, anti-Muslim racism is a daily reality for Canadian Muslims and is a particular concern to Muslim women, especially those who veil, due to their hypervisibility (Litchmore & Safdar, 2014; Rahmath et al., 2016).

The racialization of Muslims is mainly based on their physical appearances which are often conflated with religion (Garner & Selod, 2015). Khiabany and Williamson (2008) warn that when “race has been collapsed into religion”, there looms the risk that religion will be transformed into a racial category and therefore, religious rights become endangered and easily provoked (p. 86). It is important to note that ‘racializing’ or ‘racialization’ is a fluid “process where new racial meanings are ascribed to bodies, actions and interactions. These meanings are not only applied to skin tone, but other cultural factors such as language, clothing, and beliefs” (Selod, 2015, p. 79).

Racialization takes place when differences between human beings are simplified and transformed into Difference, overvaluing particular bodily differences by imbuing them with lasting meaning of social, political, cultural, economic, even psychological significance. Racialization is produced and reproduced through ideological, institutional, interactive, and linguistic practices that support a particular construction of Difference (Dominguez, 1994, p. 334).

How the process of racializing occurs can be understood as constituting Islamophobia for there is an intrinsic link between the racialization of Muslims and Islamophobia where racialization leads to Islamophobic actions and sentiments (Tariq, 2020).

Most importantly, the continuing racialization of Canadian Muslims is enacted through governmental laws and policies that Other Muslims (Razack, 2010). For example, Sharma (2006) posits, racial profiling at the borders in the post 9/11 world includes new security measures that target and racialize Muslims and their religious traditions where the image of ‘Muslim terrorists’ provides the rationale for aggressive and regressive border policies, making racial profiling and the targeting of Muslims central to border management. Further, the peace bonds, which I discussed earlier, are a glaring example of the continuing racialization of Canadian Muslim whom their Muslim identity renders them criminals in the eyes the law and provides the legal grounds for suspending the rights and protections that extend to all Canadians.

The racialization of Muslims is also maintained through a discursive process that dehumanizes Muslims and constructs them as the threatening Other, where racial differences are mobilized to justify their exclusion. Hence, the racialization of Muslims relies on the same discursive and ideological processes and structures employed by settler colonialism to maintain racial hierarchies while reserving the White identity of the nation (Bonds & Inwood, 2016). Muslims are often represented as one racialized homogeneous category (Rana, 2011) through the construction of the racist discourse about them as “the enemy within” which the racialized image of Muslims as terrorists and a security threat are normalized within public spaces and through circulating narratives (Arat-Koc, 2010, p. 269). As ‘the enemy within’, Muslims are placed within a space of exception where laws and regulations are suspended (Zedner, 2010); for this place to be sustained, the colonial narrative on Muslims as inherently against civilization and predisposed to violence is frequently invoked against the image of democratic and civilized White Canadians (Arat-Koc, 2010).

It is important to recognize and to speak about the existence of racism within contemporary Canada (George, 2000), which illustrates, within the context of post 9/11, the ease with which the citizenship of Canadian Muslims has been problematized and questioned by the state. Canadian Muslims find themselves the target for hate crimes, discrimination, racial profiling, and counter-terrorism policies, along with their negative presentation by the media all which made it normal to demoralize them and provide the justification for their subjugation and ill treatment (Perry & Poynting, 2006). This discursive and the political coupling of Islam with terrorism is strategically employed by the state to justify security measures that target Muslims and question their citizenship. Questioning the loyalty of Canadian Muslims by the virtue of their religion places them under siege that prevents them from living safely and excludes them from being treated as 'full citizens' (Arat-Koc, 2010). Further, the events of 9/11 sparked a renewal of nationalism and White supremacy in Canada and marked the beginning of an era in which the Canadian identity is reconfigured and defined "along civilizational lines", which has led to the "re-Whitening of the Canadian identity and increased marginalization of its non-White minorities" (Arat-Koc, 2010, p. 32). A significant example of the problematization of the 'Muslim identity' within Canada is in the ban on the use of religious symbols within the secular province of Quebec, which I examine later in this chapter, that mainly targets the hijab as a marker of oppression and terror and exempts Christian religious symbols.

2.3 The Discourse on the Veil

Though a comprehensive exploration of the history of veiling is beyond the scope of this study, it is important to position the discourse on the veil within a brief account of the political nature of the veil and how it has been employed within both Muslim and non-Muslim countries

to survey the bodies of Muslim women. Though veiling is not an inherently oppressive practice, it has been employed, through its history, as a tool of political manipulation by the state and its repressive apparatus through banning the practice of veiling and forcing its removal, by forcing veiling upon women, and by using the practice of veiling to push political agendas (Kahf, 2008). Importantly, the point to make clear is that, when forced upon women either socially or by the state, veiling or unveiling is a form of oppression. For example, in Saudi Arabia and Iran, veiling is legally forced upon women and those who choose not to veil face incarceration. By contrast, political manipulation and oppression of women can be seen in forced unveilings. For example, prior to the Arab Spring, veiling was banned in Tunisia's educational institutions and from government offices and veiled women were prosecuted and forced to remove their head covers (International Center for Transitional Justice [ICTJ], 2016). Since the Arab Spring in Tunisia, and though women actively participated in the revolution to remove all forms of oppression, the discriminatory treatments of women who veil have continued (ICTJ, 2016). The experiences of Tunisian women reveal the power the veil holds when employed to control the bodies of Muslim women and to continue their subjugation under patriarchal ruling. Veiling itself is not oppressive; it is when the practice of veiling is forced or banned that it becomes oppressive. When veiling or unveiling is a choice made by women, when it is a matter of personal freedom, it is a practice that can be empowering.

In the West, the veil has been politicized to push forward colonial and imperialist goals. For example, in 2001, First Lady Laura Bush, in her radio address to the nation on November 16 justified the US invasion of Afghanistan and US imperialist foreign policy based on an argument that the West ought to liberate Afghan women (Kahf, 2008). In the context of this study, what is utterly concerning is that arguments such as this originate in secular, liberal democracies, such as

Canada, where the constitution guarantees the freedom of religion and the freedom to display religious identities within the public sphere. Yet, Islam and its symbols are politicized at multiple levels within the government and by the media, resulting in an ongoing negative focus on Muslim women and on the practice of veiling (Syed, 2020). In Canada, wearing religious symbols, mainly the practice of veiling, within the public sphere has been banned in the province of Quebec, which is reinforcing gendered Islamophobia (Azam, 2020).

In her writings, Ahmed (2011) argues that though the veil as a social phenomenon continues to evolve, the veil, in its presence or absence, and what it signifies within the West have remained static: the presence of the veil is a measure of regression and incivility while its absence is an indicator of civilization. Historically, too much or too little ‘dress’ has been constructed by the colonial project as a symbol of the inferiority of people, groups, and cultures (Ahmed, 2011), and where “a historical line can be drawn between Western colonizers’ attempts in law, literature, and the arts to de-veil the imperial subject and contemporary renditions of this tropology by which the veil must be banned” (Franklin, 2013, p. 399). The focus on ‘the dress’ as a signifier often presents women who wear it as the oppressed Other, which is clearly seen within the discourse on the veil, an indigenous practice, that is constructed as a symbol of oppression and subjugation (Hasan, 2005), and occupies an integral part of the narrative on “Islam’s degradation of women and of the religion’s fundamental inferiority” (Ahmed, 2011, p. 24). Indeed, the discourse on the veil is not about veiled Muslim women themselves. Rather, it is “distinctly political, exemplifying the attempts to (re)construct identity and safeguard its boundaries by constituting a feared or even demonized [Other]” (Ahmed, 2011, p. 184).

The decontextualization of the discourse on the veil essentializes its meaning and suggests that Muslim women are “never more than the experience of their oppression or acting

on behalf of a ‘terrorist religion’” (Chakraborti & Zempi, 2012, p. 277). Further, antithesis to the image of victimized veiled Muslim women is the representation of Muslim men as barbaric oppressors who deny their women “the freedom to explore and exercise their agency” (Fernandez, 2009, p. 275). Essentializing the meaning of the veil as a symbol of oppression and terror is largely related to the ongoing attempts to generalize Islam as a hostile political ideology and to deny it the classification as a main religion, which enables the denial of the constitutional rights of Muslims under the guise of national security (Aziz, 2012). It also paves the grounds for the victimization of Muslim women who veil (Perry, 2014). Indeed, by combining the victim image with that of hostility and terror, the “language of violence weaves its way into the very fabric of the hijab” (Fernandez, 2009, p. 285).

The discourse on the veil has a dual effect on the experiences of Muslim women in which it reinforces prejudices against Muslims by “homogenizing and generalizing such oppression as representative of the whole rather than as specific to the few” (Fernandez, 2009, p. 269). It also silences their voices under the claims of freeing them from oppression. As made clear by Aziz (2012), post 9/11, women who veil are caught at the intersection of discrimination against Islam, against the racialized Muslim, and against women. These women are facing unique forms of racism and discrimination compared to Muslim men and thus, the events of 9/11 continue to impact their lives (Afshar, 2008).

In the context of violence and Islamophobia in the post 9/11... Muslim women have found themselves at the center of contestations about their identities, their nationalities and their faith and their commitment, or lack of it, to global feminist movements. Hijab... has become one of the most contested arenas both among Muslim women and between Muslim and non-Muslim women (Afshar, 2008, p. 411).

To conclude, the reductionist and oversimplified construction of the veil that overlooks the deeper and varied meanings it holds for Muslim women has been rejected by a growing number of Western and Muslim feminists who acknowledge the heterogeneity of Muslim women. While there is a general consensus among women who wear a hijab that they wear it to convey their commitment and respect for their religion and as an act of worship that brings them closer to *Allah* (Roald, 2001; Zempi, 2016), some Muslim women perceive the practice as empowering, providing them with a sense of dignity and self-worth (McDonough, 2003). Other meanings of the hijab include representing the Muslim identity and resisting the conflicting values between Islam and secular, liberal societies. The ‘new veiling’, or hijab as a form of resistance, is a movement to abandon Western clothes in favor of veiling as an act by some Muslim women to claim control over their bodies (Ahmed, 2011; Ruby, 2006), and as a means of resisting their Othering by pushing against the colonial narratives about them (Ahmed, 2011; Fernandez, 2009).

2.4 The Canadian Context

This study is happening at a time when Islamophobia in Canada has dramatically spiked (Al-Qazzaz, 2020; Statistics Canada, 2018), and when “neoliberalism and the politics of austerity inextricably shape the horizon of the possible” (Henry et al., 2017, p. 11). This study is also timely in that it coincides with increased calls by nursing scholars to uncover and directly address racism within nursing (Hilarion et al., 2018; Thorne, 2017), and to question “why does nursing remain with its head in the sand” when it comes to acknowledging and addressing the presence of racism (Thorne, 2017, p.1).

In the next section, I situate the master-narratives about Muslim women within the larger Canadian context of colonialism, multiculturalism, neoliberalism, and the Quebec ban on

religious symbols which provide the needed context for understanding the racialization processes of Muslims in Canada. I also offer an overview of racism within the context of the Canadian healthcare system and the discipline of nursing. To conclude this chapter, I provide an overview of the experiences of racialized nurses in Canada and of the experiences of Muslim nurses who wear a hijab.

2.4.1 Settler Colonialism

Canada's history as a settler colonial power continues to shape the experiences of racialized peoples within its borders through the close relationship between colonialism and racism. Colonization is not an event with a defined beginning and end; it is a continuous and ongoing process that is founded on domination and submission (Strakosch, 2015). Alfred (2004) defines settler colonialism as:

... not an historical era, nor is it a theory or merely a political and economic relationship. It is a total existence, a way of thinking about oneself and others always in terms of domination and submission that has come to form the very foundation of our individual and collective lives. It is a vast unnatural and exploiting reality that has been imposed on the world over the last five hundred years (p. 89).

Historically, settler colonialism and race/racism have been inextricably intertwined (Reading, 2013). Race, as a set of categories that places people on a hierarchy, emerged at the same time and functions alongside colonization (Loppie et al., 2014). Race, therefore, is the product of the process of racialization (Sayyid, 2014). Race, as an arbitrary system of classifying people, is a modern concept that was constructed to drive and sustain the institution of slavery and the colonization of non-Europeans and to legitimize their exploitation and the economic benefits gained as a result (Anderson-Gold, 2002). Whites were considered biologically superior

and closer to the Christian God while dark-skinned people were constructed as intrinsically inferior, less human, and farther from civility and intelligence (Angelini & Broderick, 2008; Henry & Tator, 2009). Sayyid (2011) argues:

Races were never exclusively biologically determined but rather socially and politically produced. Bodies were marked at the same time as religion and culture, history and territories; these markings were used to group socially fabricated distinctions between Europeaness and non-Europeaness (p.4).

Therefore, the concept of race legitimized exploitation and the economic benefits gained as a result. Within Canada, race was employed through adopting and embracing the idea that Indigenous peoples were inferior, allowing the settlers to mask themselves as saviors in the settlement of North America (Smedley & Smedley, 2012).

Canada is a settler colonial state building project. Wolfe (2006) contends that the processes and practices of settler colonialism are not a matter of the past but are ongoing. Hence, Canada is not a postcolonial state. Though often conflated with colonialism, settler colonialism is a distinct formation of imperialism. The irreducible element of settler colonialism is the ultimate goal of expropriating land and resources through displacing Indigenous peoples from their land (Wolfe, 2006). It is based on what Wolfe terms the “logic of elimination”, wherein it operates on the premise of claiming a territory, and therefore requires that the original owners of that territory be eliminated by any means necessary (p. 387). This dispossession is achieved in many ways, often either through treaties with Indigenous peoples or violent possession of lands (LeFevre, 2015). Settler colonialism, thus, differs from colonialism whose primary objective is the temporary control over an Indigenous population and the exploitation of their labor and natural resources (Hughes, 2020). In contrast, settler colonialism is permanent in which settlers “come to stay” (Veracini, 2013, p.

313), which centers colonial relations on possession of land rather than labor and resources. And for settlers to be able to claim the land, Indigenous peoples must be eliminated both physically and politically or displaced (Wolf, 2006). Veracini (2016) explains that in contrast to colonialism, settler colonialism “supersedes rather than reproduces the colonial rule of difference; settlers win by discontinuing unequal relationships rather than maintaining them” (p. 3). As well, “[t]he racist discourse of settler colonialism erases the political, epistemic, cultural, and ecological sovereignty and diversity of Indigenous Nations” (McKay et al., 2020, p. 4).

Settler colonialism is an ongoing project with embedded social structures that privilege settlers and shape every aspect of contemporary life (Wolfe, 2006). Contemporary Canadian settler colonialism continues to thrust the state into an era of unequal powers and race relations. Yet, as Nelson (2012) argues, “the ideological side of colonization is shrouded in popular myths that are taken for granted in the public consciousness, making it much harder to identify” (p. 6). While Islam has historically been employed to present the good image of the West and to frame what went well within the West in contrast to Islam and Muslims, “Islamophobia has been denied as a problem and defended as a practice. Islamophobia has been presented as nothing as sordid as racism, but rather a rational response to real threats to western, nay universal, values” (Sayyid, 2011, p. 3). The coloniality of Islamophobia is evident in the mistreatment of Muslims, more acutely post 9/11 (Razack, 2005; Thobani, 2007, 2018), in the recent rise in anti-Muslim racism in Canada during the COVID-19 pandemic (Al-Qazzaz, 2020), and in the circulation of imaginary narratives about the inherent violence of Muslims, creating categories of those “who are deserving” as ‘good Canadians’ and those who are unworthy and depart from this ideal (Razack, 2008, p. 9). The colonial roots of Islamophobia are also evident in the colonial rhetoric towards Muslim women who wear the hijab in which

they are subjected to all aspects of anti-Muslim racism from receiving dirty looks to random threats and acts of violence regardless of their phenotype (Sayyid, 2011). Indeed, Islamophobia is structured around the construction of the colonial discourse around the monolithic oppressed Muslim women who wear a hijab as a colonial object, in which this construction is “the basic pillar that structures Islamophobia in all its different forms” (Miró, 2019, p. 102). Further, settler colonialism continues to function today through neoliberal policies, as both settler colonialism and neoliberalism are driven by the possession of power “and work through racialized hierarchies” (Strakosch, 2015, p. 33).

2.4.2 Neoliberalism

The rise of colonialism corresponded with the rise of neoliberalism within the colonising states, which points to the interconnectedness between the two systems. Neoliberalism and settler colonialism are manifestations of a single Western structure of domination that is driven by possession of property and work through racialized hierarchies. Mignolo (2011) argues that coloniality and neoliberalism are similar in that they share the same capitalist logic. This relationship is also emphasised by Strakosch’s (2015) argument that “ongoing settler colonial hierarchies have been rearticulated through, rather than revived or transcended by, neoliberal frameworks” (p. 3).

Neoliberalism relies on a language of economic insecurity as justification for comprehensive reforms to increase competitiveness, efficiency and responsibility, and to delegitimize claims on the state. It celebrates the self-reliant, capable individual and denounces state regulation of such individuals as unproductive. However, it simultaneously allows increased coercion by the state where individuals or groups are deemed to lack appropriate capacity (Strakosch, 2015, p. 4).

Neoliberalism, therefore, captures the creativity of the colonial settler state through which the hegemony of White Canada is constructed along with sustaining “an interrelated settler colonial liberal capitalist system” (Hampton, 2019, p. 374).

Neoliberalism, which has been the dominant political ideology in Canada since the 1980s, is partly rooted in “the classical eighteenth and nineteenth century liberalism” (Luxton & Braedley, 2014, p. 7), and is defined as “the agenda of economic and social transformation under the [system of] free market that has come to dominate global politics in the last quarter-century” (Connell, 2017, p. 23). Neoliberalism is a set of political, economic, and social practices geared toward restoring the power of the economic elite through cuts to social welfare systems and the creation of new markets (Harvey, 2007).

The main governing value of neoliberalism is closely tied to the capitalist stance on reserving and safeguarding the individual freedoms of consumption and competition through market deregulation and privatization (R. Gupta, 2012). As an ideology, neoliberalism is informed by efficiency and “an ‘ethic’ of cost-benefit analysis” (Apple, 2005, p. 214). This neoliberal thought is more than a set of market rules and principles restricted to the economy; it affects all aspects of society (Harvey, 2007). In this vein, what is different or new about liberalism is that neoliberalism has brought the logic of the market to almost every aspect of social life (Luxton & Braedley, 2014), while it has continued to facilitate settler colonialism by depoliticize colonial hierarchies using the language of the market.

[N]eoliberalism brings a newly flexible relationship between inclusion and exclusion. In the neoliberal era, citizenship detaches from secure, categorical inclusion and permanent recognition of capacity. Where previously citizenship largely coincided with capacity, neoliberalism introduces the figure of the incapable citizen. This ambiguous position

allows a subject to be formally included as a citizen, and simultaneously excluded from regimes of freedom for being temporarily ‘undeserving’ of this existing citizenship (Strakosch, 2015, p. 7).

The negative effects of the neoliberal ideology in Canada are widespread, including the assault on the welfare state through privatizing public assets and institutions (Connell, 2017), and cutting funds or defunding many social services and programs, including anti-oppression and anti-racism research (Henry et al., 2017). These effects are also seen in the shift towards individualism and in the view of diversity as experienced individually, which produces and fuels systemic racism and provides the cover for its denial. By attaching responsibility to the individual, neoliberal policies deny systemic inequities (Luxton & Braedley, 2014).

A main critique of neoliberalism is in its faulty premise of the freedom of individuals to choose, as it does not acknowledge that individuals usually make choices under conditions which they have no control over; conditions that are created by a few powerful people (Luxton & Braedley, 2014). Therefore, neoliberalism gives cover to systemic racism and contributes to the silence on racism by perpetuating an ideology of color-blindness while legitimizing the existing socioeconomic and political structures that privilege the dominant group. Within this ideology of color-blindness, racism has continued to operate within the neoliberal Canada and within Canadian nursing. Therefore, the critical questioning of who benefits from neoliberal practices and policies and who loses exposes covert systemic racism and the existing tension between the freedom of individual choice and the actual practices of neoliberalism that “have produced benefits and losses on the bases of gender, race, and class” (Luxton & Braedley, 2014, p. 12). Luxton and Braedley (2014) go further in their criticism to assert that “neoliberalism was developed in part to counter equality demands of feminist, anti-racist, and anti-imperialist

activists, as well as the socialist demands to end class exploitation” (p.12).

The role neoliberal policies play in favoring the private business sector are instrumental in furthering the privileges of those who are powerful and socially advantaged based on their gender, class, race, and relationship to colonialism. Neoliberal thinking has also projected an image of the ‘ideal citizen, ‘someone who is rational, practices the freedom to choose, is responsible for the outcome of ones choices (Abu-Laban & Gabriel, 2002), and as one who does not identify with any form of group-based identities (Razack, 2008). The construct of the ‘ideal citizen’ provides the ground for denying structural racism by casting those who are racialized as undeserving of citizenship rights as they fail to assimilate.

In this vein, Kazemipur (2014) argues that Muslims are unable to integrate to Canada due to their religion. Specifically, that Muslims are perceived as unable or unwilling to integrate into liberal democracies, in large part due to their practice of Islam. Thus, their religion poses an inescapable obstacle to integration that in turn puts Canadian Muslims at social and economic disadvantages. Kazemipur, drawing on extensive data, demonstrates that though the integration of Muslims in Canada is not problematic in the same way that it is in Europe and the United States, the challenges Muslims face in the social and economic domains in Canada need to be addressed in order to end the problematic treatment they have endured, especially since 9/11. The events of 9/11 also mark a transition in Canada from a focus on multicultural practices that were once seen as relatively successful in integrating culturally diverse groups to a national security state and where multiculturalism as a policy is seen by some as encompassing policies and practices supporting communities that are connected to terrorism and pose a security threat to Canadian citizens (Mann, 2017).

2.4.3 Multiculturalism

Bourassa (2021) maintains that although neoliberalism and multiculturalism are distinct, they are not separate; they “have cohered or coalesced, and actually developed in tandem, as demonstrated by much of their shared language and objectives” (p. 258). More specifically, while neoliberalism often deploys multiculturalism by “appropriating and absorbing the language, concepts, and practices of multiculturalism” to contain and manage the demands of social movements, and where the proponents of multiculturalism have also adopted the language and the logic of neoliberalism (Bourassa, 2021, p. 258). Multiculturalism is an ideology and a state policy that was adopted in 1988 through the Canadian Multiculturalism Act and has been enacted at various institutions and levels of the government (Bannerji, 2000; Henry & Tator, 2009). Multiculturalism is based on the notion that diverse cultural, racial, religious, and lingual backgrounds are important and beneficial to Canadian society (Henry & Tator, 2009). It also promotes the values of tolerance and equal opportunity while constructing a concept of cultural homogeneity that reflects the dominant group (White Canadian) in relation to all other cultures (Gundera, 2001). A critical aspect of the implementation of multiculturalism as a policy is the framework of reasonable accommodation that focuses on differences, the state’s role to accommodate these differences and the extent of the accommodation (Young, 2007).

Multiculturalism is criticized as a fundamentally flawed approach to addressing cultural and racial diversity in Canada. This policy is seen as a continuation of positioning racialized groups at the margins of society while privileging the dominant cultural group (Henry & Tator, 2009). Grounded in its own discourse of promoting tolerance and equal opportunity a denial of the existence of racism and a maintenance of the superiority and power of White Canadians (Hage, 2000). Multiculturalism, in this vein, has failed to address systemic racism in Canada.

This criticism goes further to implicate multiculturalism as providing a cover for racism to thrive by shifting the focus from racism and power relations to focus on cultural diversity (Bannerji, 2000). The emergence of multiculturalism as both an ideology and a policy has provided the grounds to push forward the neoliberal discourse in which the values of individualism, tolerance, and equality are promoted and supported (Bannerji, 2000). Arat-Koc (2005) explains that inherent within the notion of tolerance as a central tenet of neoliberal multiculturalism is a clear imbalance in powers between those who are tolerant and those who are being tolerated, where White Canadians are the ones in control of deciding whether to accept the presence of others among them. The concepts of tolerance and harmony “tend to conceal the messy business of structural and systemic inequality and the unequal relations of power that continue to exist in a democratic liberal society” (Henry & Tator, 2009, p. 15). Multiculturalism, thus, fosters an illusion of inclusion and tolerance and is a way of maintaining existing practices; it focuses on limiting diversity to something that is symbolic, rather than driving actual political and transformative change (Henry & Tator, 2009). Indeed, inequities are infused within the language of multiculturalism (Arat-Koc, 2005).

Another critique of multiculturalism is that it is more divisive than inclusive by shifting the focus from ‘about us’ to ‘about them’ (Winter, 2015). Thobani (2007) argues that multiculturalism maintains the status of racialized people as strangers to the national fabric. This argument is supported by Bannerji (2000) who explains that language around multiculturalism employs colonial and racist discourses. The figure of ‘the stranger’ within the multicultural discourse is necessary for the nation to exist and for national identity to be forged. The figure of the stranger is used as a measure to which national identity is defined against (S. Ahmed, 2000).

Though multiculturalism has been blamed for endangering the safety of the nation and its

citizens by protecting communities that sponsor terrorism, it has functioned as a cover for the heightened ill treatment of Muslims post 9/11, which underscores the status of Canada as a racial state along with its role as a security state (Mann, 2017). As a divisive policy that is focused on differences, the departure of Muslims from White Canadians is emphasized as a source of threat, allowing for the re-emergence of White identity in contrast with the uncivilized threatening other, which is central to the formation of Canadian nationality in the post 9/11 era (Thobani, 2007, 2018). In the same vein, the intersections of gender, race, and religion within the context of multiculturalism in Canada pave the way for the homogenous construct of Muslim women who veil that leaves no room for the diversity between and among them. Instead, the complexities of these Muslim women are irrelevant, and their individualities are erased.

2.4.4 Religious Symbols

The use of religious symbols in private and public spaces is an important aspect of religious freedoms (Aydin, 2015). As the influx of immigrants and refugees has begun to change the composition of many nations, including Canada, the issue of wearing religious symbols in the public sphere has ignited an ongoing debate on religious freedoms and the extent of accommodating religious groups (Barnett, 2011; Stolle et al., 2016). The public and political rhetoric dominating this debate reflects the power White Canadians hold in deciding who belongs and their control over public space that is socially produced, shaped by power relations, and racialized (Razack, 2002). Since 9/11, public space has become increasingly racialized through the Othering and the victimization of Muslims and, more specifically, Muslim women within it. More recent violence towards Muslim communities has been on the rise in Canada in the context of the global pandemic in which “Canadian Muslims are carrying another burden alongside the stressors of the pandemic: the stigma of exclusion” (Al-Qazzaz, 2020, para. 9).

The racializing of public space, as asserted by Razack (2002), necessitates the exploration of how Muslims, mainly Muslim women, experience their presence in it and the power relations that are enacted and produced within it. This can be critically examined through an analysis of the ban on the use of religious symbols in the province of Quebec. Quebec has been at the center of the debate on the extent to which religious practices are to be accommodated. Unlike the rest of Canada, because of its history, secularism and national identity are inextricably linked in Quebec. It has been argued that this has resulted in pressure placed on Quebec policy makers to balance the official multicultural policies of English-speaking Canada with its tradition of secularism since the Quiet Revolution of the 1960s, which resulted in the repudiation of the Catholic Church and its role in public life and the creation of an opening for a new secular conception of the Quebec nation (Dufresne et al., 2019; Reitz et al., 2017). Further, Quebec has never espoused multiculturalism as its policy and instead, it has adopted an intercultural policy model that gives precedence to Francophone culture and language in approaching diversity and the integration of immigrants (Bouchard, 2016). In Quebec, Selby (2014) argues, “the covered female body evokes vestiges of oppressive Catholic patriarchal religiosity” (p. 441). Shelby explains that the contested historical relationship between Quebec and the Catholic Church has shaped the province’s stance on women’s dress and where dressing in a neutral way and keeping the face uncovered are perceived as protections against the threat of religion and religious practices.

Accounting for the colonial dimension of nation building is critical to the understanding of the ban of religious symbols in Quebec, which is “infused with colonial meanings” and relations of power that inform the racialized and gendered dimensions of the ban as a continues in the legacy of discriminatory policy that is based on the securitization of Muslims in Canada

(Laxer, 2019, p. 9),. Beaman's (2017) analysis of the case of Saint-Sacrement Hospital's crucifix illustrates how discourses on diversity signal power imbalances within the ban on religious symbols. Officials of Saint-Sacrement Hospital in Quebec removed a crucifix from the front entry of the lobby in February of 2017 to preserve the site's neutrality. As its removal was being debated, religion was not used in arguments for its removal or for its restoration. Rather, in the articulated demands for its return to the site, cultural and heritage values were frequently evoked by politicians and members of the public. Legault, the leader of the Coalition Avenir Quebec (CAQ) party and premier of the majority government in Quebec, stated that despite striving to maintain the secular state of the province, he did not acknowledge the crucifix as a religious symbol, but rather a cultural one. Thus, the crucifix, and perhaps similar symbols, would not be subject to his party's ban (Gould, 2018). Such statements by politicians and members of the public surrounding the crucifix of Saint Sacrement Hospital expose the illusive message that White Christian Canada has culture and heritage in need of preserving while 'Others' have religion; that "immigrants from the 'Orient' who need to be reminded of Christianity's place of privilege... and that new religious diversity is not characterized by equality or multiculturalism, but a hierarchical configuration that preserves existing power relationships" (Beaman, 2017, p. 9). Indeed, "[d]espite multiculturalism, Christianity as the majoritarian religion still retains a position of privilege, albeit now under the guise of heritage and culture" (Beaman, 2017, p. 9). CAQ's agenda also highlights the spread of the populist, right-wing movement in Canada and signifies a clear retreat from multiculturalism that is not confined to the province of Quebec but is also happening in the rest of Canada (Bilge, 2013).

Premier Legault, as a part of his nationalist agenda and as promised during the 2018 election, pushed to implement a ban on employees in the public sector from the use of all

religious symbols (from face covering religious dress, like niqab, to wearing a headscarf or hijab and all other forms religious symbols) (Zhou, 2018). Since, The Laicite Act, or Bill 21, which makes it illegal for public servants in the position of authority to wear religious symbols at work, has become a law. Also, in contrast to other secular nations such as Italy and Spain, Quebec's government rationale for outlawing the use of head covering was not based on secular values, but to safeguard the rights of women (Shelby, 2014). Hence, the public debate has been centered on the hijab as a symbol of the oppressed Muslim woman and Bill 21 is presented by its supporters as a way to emancipate Muslim women and free them from oppression (Lord, 2020). On the other hand, opponents of Bill 21 argue that it reinforces gendered Islamophobia (Jahangeer, 2020), and that it pressures Muslim women to choose between their religion and public services which further marginalizes them from obtaining employment within the public sector and from accessing its services (Lord, 2020). It is also a form of oppression enacted by the state and its lawful citizens who assign themselves the authority to regulate and survey the bodies of Muslim women.

Bill 21 is a true manifestation of gendered Islamophobia that is enacted through anti-veiling on a systemic level and is a demonstration of the dialectical process in which the state and its apparatus legitimize Islamophobia.

On a systemic level ... anti-veiling involves a process that makes use of state apparatuses to contain the contagion that veiling is thought to represent. Anti-veiling encompasses the assumptions, affects, and arguments behind the debates, discourses, and laws aiming to require Muslim women to unveil before entering certain spaces, at certain times, or in order to undertake certain forms of employment. It is the presumption that, if politicians or the general public claim to want to protect certain values such as secularism,

neutrality, or gender equality, then these values should outrank human rights that are constitutionally entrenched or internationally protected. It is the willingness to limit the freedom, opportunity, and mobility of a person based on which parts of their bodies they render visible (Jahangeer, 2020, p. 119).

When Muslim women are victimized within public space, when they are asked to remove their hijab, or when their hijab is forcefully removed, these actions can be seen as protecting Canada and Canadians from those who are inferior, foreign, and dangerous, which negates the notion of Canada's modern national identity as a multicultural nation that encompasses a harmonious mosaic of diverse cultures.

The Quebec ban on religious symbols, the racialization of public space, and the restrictions of religious freedoms support the argument on the contradictory processes of neoliberal multiculturalism, the inherent tension in its processes (Arat-Koc, 2005), and its failure to maintain its promises of ensuring the rights of racialized people and communities to express their religious and cultural identities without the fear of being stigmatized or discriminated against (Nagra, 2017). This ban provides a lens into the ways in which White hegemony and dominance are maintained. Though it can be argued that Canada has attempted, through the introduction of multiculturalism, to move beyond its history as a White colonial settler state and to project itself as a liberal democracy free of racism (Thobani, 2007), Canada remains a colonial nation that continues to enforce its White national identity.

2.5 The Contexts of the Canadian Healthcare System and the Discipline of Nursing

As I explained earlier, I am situating this study within an understanding of the historical and sociopolitical context of Canada that lays the grounds for anti-Muslim racism. I am also

locating it within the context of racism within the Canadian healthcare system. Understanding the experiences of Muslim nurses who wear a hijab is also framed by a recognition of racism within the discipline of nursing and how it functions through the claims of color-blindness and the denial of its existence.

2.5.1 Racism in the Canadian Healthcare System

Canada's healthcare system claims to preserve and enact the core values of equity and fairness. By contrast, it continues to be informed by the colonial history of the nation and by a preference for English and biomedicine knowledge and wisdom (Nelson, 2012). Therefore, as in the case of Indigenous peoples, other ways of knowing, including traditional medicines and knowledge, are devalued (Phillips-Beck, 2020). Hence, Indigenous peoples experience "epistemic racism... reflected in the dominance of Western biomedical knowledge and marginalization of other ways of knowing and practicing in the Canadian healthcare system" (Allan & Smylie, 2015, p. 5). The notion that Canada's healthcare system is an aspect of the national commitment to social equity and social justice deters from raising the issue of racism and interrogating racial inequities within it. Importantly, systemic racism in the healthcare system is a consequence of multiple confounding factors, including ongoing colonialism, and the lack of diverse representation in nursing. In turn, events like 9/11 and the COVID-19 pandemic heighten pre-existing discriminatory practices and policies woven into the system, thereby bringing them to the surface (Etowa & Hyman, 2021; Guttman et al., 2020). As such, these events exacerbate existing structures of oppression and inequities in the healthcare system, further intensifying the racism that racialized people and Indigenous peoples face when accessing healthcare services.

Encountering systemic racism within the Canadian healthcare system is a regular experience for racialized Canadians and Indigenous peoples (Blair et al., 2013; Phillips-Beck et al., 2020). Racism is experienced at the interpersonal level within the provision of care delivery and through policies and practices at the system level (Gunn, 2014). Leyland and colleagues (2016) explicate that interpersonal racism functions as a catalyst for systemic racism through enacting policies and practices that grant one group disproportionate power and greater access to care and resources compared to other groups. The pervasiveness of interpersonal racism makes it challenging to identify, as it is subtly woven into the subconscious of people and enacted through attitudes and values that attach positive meanings to White patients or colleagues in contrast to those who are racialized (Blair et al., 2013). Further, Indigenous peoples, through their interactions with the system, navigate the erroneous assumptions and negative stereotypes (Leyland et al., 2016), and experience Othering and of being treated as a problem (Gunn, 2014; Loppie et al., 2014).

Jacobs (2020) stresses that as it stands, racism in healthcare is regularly experienced by racialized women and that there is no safe space for racialized and Indigenous patients within the current healthcare system in BC. The prevalence of racism in the healthcare system can be seen in a recent review to investigate an allegation that staff in at least one BC hospital emergency room participated in a game to speculate the blood alcohol levels of Indigenous patients who came in seeking urgent care (Jacobs, 2020; Turpel-Lafond, 2020). Though nothing came of the investigation of this allegation, it led to renewed calls to address systemic racism in the healthcare system. The review, however, clearly confirmed that Indigenous-specific racism persists within the healthcare system and is pervasive across all regions and the different healthcare settings (Turpel-Lafond, 2020).

Examples of racism within the Canadian healthcare system are not limited to cases in one province, fragmented incidents in a few hospitals, or actions by a few people: it is widespread. Notably, Joyce Echaquan, an Atikamekw woman, recently died in a Quebec hospital and recorded her last minutes alive as she called for help while hospital staff insulted her and called her degrading and racially laden names (Shingler, 2020). Yet, Quebec's Premier Legault denied that this incident is an indication of systemic racism (Shingler, 2020). Nonetheless, it stands that Joyce Echaquan's death is another hurtful example of systemic racism and its, quite literally, fatal ramifications (McCallum & Perry, 2018). Systemic racism of this kind also manifests indirectly through preventing racialized and Indigenous peoples from accessing public services, including healthcare services. Mahabir and colleagues (2021), who conducted a recent study to examine the experiences of everyday racism in Toronto's healthcare system, report pervasive experiences of racial discrimination among racialized patients who describe being treated as inferior by healthcare providers and facing challenges in accessing services and quality medical care. Further, racialized women report experiencing racism in their contacts within the Canadian healthcare system (Spitzer, 2004; Reitmanova & Gustafson, 2008).

Experiencing health disparities due to structural barriers, such as racism, is not a new challenge for racialized people and communities in Canada (Etowa & Hyman, 2021). However, in the context of COVID-19, they have experienced greater healthcare inequity, as the pandemic has deepened economic and social inequities (Etowa & Hyman, 2021; Smith et al., 2021; Tuyisenge & Goldenberg, 2021). Though the rates of COVID-19 infection and mortality in racialized population in Canada are unclear due to shying away from collecting race-based data, the limited available data show that in Ontario, for example, racialized people were overrepresented in hospital admissions due to the COVID-19 pandemic and that the rates of

infection are three times higher in areas where racialized people live (Etowa & Hyman, 2021; Guttman et al., 2020).

It is within the context of the Canadian healthcare system that nurses who wear a hijab practice and against which their experiences are constructed. The racialization of Canadian Muslim women, the rampant experiences of racialized and Indigenous peoples with racism as they access healthcare services, and the persistence of racism within the Canadian healthcare system emphasize the importance of the study in uncovering power structures that sustain Islamophobia.

2.5.2 Racism in Canadian Nursing

The racialization of Muslim women who wear a hijab and the persistence of Islamophobia require an interrogation of racism within Canadian nursing to reveal how racism continues to function within the discipline and to grasp the context of which Muslim nurses who wear a hijab practice. Democratic racism (Henry & Tator, 2009) provides a model for understanding how racism continues to persist in Canadian nursing, as it explains the contradictions between the egalitarian values of nursing and what racism entails. Democratic racism is a product of applying the argument of liberal democracy that the values of justice, equality, fairness, and inclusiveness cannot coexist with racism (Henry & Tator, 2009), which results in the transformation of racism from “visible and physical” to one that is more subtle and subconscious (Farr, 2009, p. 170).

Whiteness also plays a large role in the construction of democratic racism as an ideology that represents a set of values, practices, and beliefs, and creates a hierarchy that privileges some and subjugates others, and where being White is automatically associated with privileges and

superior roles in all sectors of society (Henry & Tator, 2009). Whiteness is constructed as a default standard in which racialized people are contrasted against; it is “an invisible veil that cloaks its racist deleterious effects through individuals, organizations, and society” (Sue, 2006, p. 15). Whiteness, therefore, encompasses the aspect of racism that elevates White people and maintains White privilege. Meanwhile, White privilege refers to the unearned benefits of wealth and power of White people who position themselves as neutral, and where the dominance of White privilege and the uncritical acceptance of it continue to sustain racism (Varcoe & McCormic, 2007). Democratic racism also thrives within the discourse of denial (Henry & Tator, 2009), which upholds the fundamental assumption that racism could not exist within a democratic society, and when racism is clearly undeniable, it is dismissed and contributed to isolated individual acts that do not reflect the collective (Henry & Tator, 2009).

Democratic racism operates in nursing through the assumption that racism could not exist or function alongside the discipline’s core values of caring, empathy, and professionalism (Barbee, 1993). It is also fostered through White privilege and the construct of the ‘White good nurse’. Giddings (2005) explains:

The ideological assumptions and associated discriminatory practices captured in the construction of the ‘[w]hite good nurse’ are so integrated within the routines of everyday mainstream nursing that they are normalized. It is the normalization of social injustice within the constructed meanings and everyday routines of nursing practice that makes discrimination invisible (p. 310).

Racism is also frequently denied as a problem in nursing. The denial of racism by constructing the nurse as a professional who is colorblind is assumed through the elusive and intangible

nature of democratic racism (Barbee, 1993). Though there is growing evidence on the experiences of racialized nurses that reflect how gender, race, and class intersect to produce ongoing practices of oppression within Canadian nursing (DiCicco-Bloom, 2004; Gupta, 1996, 2008, 2009; Hagey et al., 2001; Turritin et al., 2002), there is minimal discussion of racism in nursing literature and many nurses avoid talking about or acknowledging its presence (Gupta, 2008; Gustafson, 2007; Porter & Barbee, 2004; Thorne, 2017).

The denial of racism within Canadian nursing and the inability of the discipline to see itself as perpetuating racist practices have sustained “the privilege of those who fit the ideal of the ‘[w]hite good nurse’ and the marginalization of those who do not” (Giddings, 2005, p. 311). In this vein, the silence on racism within nursing “results in a normalization of race-based challenges, compounding the effect of discriminatory experiences” (Nunez-Smith et al., 2007, p. 49). The pervasiveness of racism in Canadian nursing compelled nursing scholars to speak against it and to call on the discipline to end its silence and denial of its existence (Hilaro et al., 2017; Thorne, 2017). Indeed, there is an urgent need for transformational change in nursing to mitigate racism and its negative effects, which can be gleaned from documented experiences of racialized and Indigenous nurses in Canada who stand witness to the state of racism in nursing and how it continues to support discriminatory and differential treatments. Concurrently, the claim that racism has no place within the discipline is employed to turn the gaze away from the critical examination of the power structures that fuel it.

2.6 The Experiences of Racialized and Indigenous Nurses in Canada

Across the literature on the experiences of racialized and Indigenous nurses in Canada, themes of racist acts, Othering processes, and differential treatments are strongly threaded. Both Gupta (2008, 2009) and Modibo (2004) share the stories told by Black nurses about being discriminated

against by White managers who did not offer them the same opportunities as their White colleagues. Modibo (2004) also documents accounts of verbal abuse experienced by Black nurses from patients and their families, and the lack of support from other White nurses working alongside them. Turriffin et al. (2002) also capture the experiences of racialized nurses who immigrated to Canada with individual and systemic discriminatory practices, escalating conflict, and of being labelled “as aggressive, rebellious, unmanageable” (p. 659). Discriminatory actions towards racialized nurses persist even after complaints of being discriminated against by management are brought forward. Gupta (1996, 2008) reports that Black nurses in Ontario who spoke of being discriminated against by their managers were targeted and evaluated differently than other nurses. The experiences of being retaliated against were met by denial of the problem of racism by colleagues and employers (Gupta, 2008; Hagey et al., 2001; Turriffin et al., 2002). The careers of managers who are accused of racism and deny it are usually left unscathed (Hagey et al., 2001). Though there is limited research exploring the experiences of Indigenous nurses in Canada, available research captures the common and daily experiences with both subtle and blatant racism from patients, other nurses, and management (Vukic et al., 2012).

Gupta (2008) brings the focus to the various forms of racism that are present in the daily interactions between Black nurses. Studying the experiences of Black female nurses in Ontario, Gupta explains that five Black and Filipino nurses occupied senior managerial positions. Their lack of representation at the leadership levels were sustained by systemic actions through management training junior White nurses for managerial positions while bypassing racialized nurses with higher seniority. Furthermore, the existence of a few minority nurses in marginal positions served as a ‘token hire’, a strategy that embodied democratic racism within organizations in which a limited number of racialized people are hired and their hiring is used to

support the organizational claim of maintaining equal opportunities and to support the denial of discriminatory practices (Gupta, 2008; Henry & Tator, 2005;).

Moreover, Gupta (2008) points to the prevalence of discriminatory actions throughout recruiting, interviewing, reference checking, and hiring. Black nurses were perceived by other nurses, managers, and patients as less educated and under qualified. Frequently, they were denied promotions, excluded from recruitment for managerial and leadership positions, and were referred to as lacking required skills. Further, when Black nurses applied for disability or requested sick time, they were regarded with suspicion and treated discriminately compared to White nurses who requested the same accommodations (Gupta, 2008). Black nurses documented that when they challenged the status quo, those who held power, mostly White managers, would work to put them back in their place. Such experiences of Black nurses in Canada capture the notion of racial inferiority of Black women and the negative representation of them as “less intelligent, less competent, less skilled and less disciplined” (Calliste, 2010, p. 288).

Internationally educated nurses practicing in Canada also experience racism inflicted by their colleagues and managers, tolerate verbal and physical violence, and identify their coworkers as the main source of emotional abuse (O’Brien-Pallas & Wang, 2006; Tregunno et al., 2009). Often, the education and the intelligence of internationally educated nurses and nursing faculty are questioned (Scammell & Olumide, 2012). Hawkins and Rodney (2015) discuss how nurses from the Philippines who immigrated to Canada experienced multiple challenges when attaining recognition for their RN licensure and in securing employment. These nurses were required to have further education while they were not offered mentorship or included in hospital training programs, indicating the presence of racialized hierarchies within nursing. Their findings point to the failure of the federal government to support the nurses

through transitioning, underscoring individualism as a neoliberal value whereby individuals are responsible for overcoming the obstacles they face (Hawkins & Rodney (2015). For example, these nurses were responsible for paying to further their nursing education through private colleges while having limited access to resources (e.g., childcare). After all, nurses who experience racism point to the combination of a lack of knowledge on diversity, White privilege, and White dominance at the higher levels of nursing, including regulatory bodies, as the underpinning of racism in Canadian nursing (Hagey et al., 2001).

2.7 The Experiences of Muslim Nurses Who Wear a Hijab

There exists a plethora of research exploring the intersections of gender, race, and class, and how these intersections shape the experiences of racialized women (Collins, 1993; Crenshaw, 1991; Grillo, 1995; Mohanty, 2003). However, there is limited research examining social locations of Muslim women that are produced by the intersections of their gender, race, religion, and other axes of difference. This gap is clear within the Canadian context and becomes even more pronounced in the very limited research on the experiences of nurses who wear a hijab. The experiences of women who veil along with the persistence of racism within Canadian nursing and the documented experiences of racism by racialized and Indigenous nurses accentuate the value this study holds in not only illuminating the voices of the nurses who veil but also unveiling power relations that operate to preserve racism within nursing.

Clark and Saleh (2019) underscore the need to explore the experiences of nurses who wear a hijab drawing from the theoretical and methodological underpinnings of CRF, intersectionality, and narrative inquiry. Informed by the work of Kulwicksi and colleagues (2008), Clark and Saleh (2019) argue that this methodological approach offers a point of

resistance by using the stories of Muslim nurses to challenge the narrative about them and to transform nursing policy, practice, and education. To determine the effects of 9/11 on Arab American nurses' experiences with workplace discrimination, Kulwicky and colleagues (2008) surveyed 34 Muslim nurses from varied practice settings. They described experiencing intimidation, name calling, and negative remarks about their religious practices and their hijab from patients, nurses, and staff members (Kulwicky et. al, 2008). This study is one of the very few studied exploring the effects of 9/11 on Muslim nurses and how the terror events have shaped their experiences with anti-Muslim racism within their practice settings. This study also brings attention to the need for supporting the nurses while creating work environments that have zero tolerance for discriminatory behaviors and actions.

Although a few anecdotal reports and editorial commentaries explore the experiences of Muslim nurses who wear a hijab (Arif, 2014; Saleh, 2017), little is known about Muslim nurses' experiences within the Canadian context. There is a clear need for research that addresses this gap and explores the experiences of Muslim nurses within educational and practice settings (Hansbrough et al., 2018). The population of Muslim nurses who wear the hijab has been neglected by scholars despite their hypervisibility, the surge of anti-racism in Canada, and the racialization of Canadian Muslims.

In this chapter, I presented the master-narratives surrounding Muslim women who veil and located their experiences with Islamophobia within the discourse on the veil, the historical and sociopolitical context of Canada, and the context of Canadian nurses, to glean a background for understanding and contextualizing the experiences of nurses who wear a hijab. The master-narratives lend the backdrop in which the nurse's counter-narrative is constructed to present the voices of the nurses and to challenge and deconstruct the homogeneous and

negative representations of them. In the next chapter, I provide a discussion of the theories of CRF and care ethics which inform the exploration of the nurses' experiences.

Chapter 3: Theoretical Positioning

3.1 Introduction

The epistemological and ontological underpinnings of this study is social constructionism. Social constructionism views all knowledge and all meaningful realities as “constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context” (Crotty, 1998, p. 42). Social constructionists, therefore, challenge the idea of one essential Truth (Kharbach, 2020). In addition, this study is informed by the theories of critical race feminist (CRF) and feminist care ethics, which are congruent with the philosophical underpinnings of constructionism. A main principle ontological underpinning of CRF is that identities are socially constructed and that experiences of racialized women are a product of those identities (Pratt-Clarke, 2010). CRF is founded on the ontological assumption that race as a concept is socially constructed (Shih et al., 2007), and that racial differences are “invented, perpetuated, and reinforced” (Gillborn, 2015, p. 278), resulting in a society that is “fundamentally racially stratified and unequal, where power processes systematically disenfranchise racially oppressed people” (Hylton, 2013, p. 24).

Feminist care ethics conceptualizes gender and other identities as socially constructed and closely connected to power structures (Okano, 2016). Okano explains that feminist care ethics is critically attentive to power relations that are maintained through established hierarchies based on gender and a hierarchy of labour division, placing women in socially subordinate locations, and making them more vulnerable to social and political forces. Hankivsky (2014a) explains that feminist care ethicists who take a social constructivist approach are attentive to the context, relationships, interdependence, and have a clear commitment to social justice. Caring is more than an act; it involves feelings, attitudes, and a state of mind that are directed towards

others and are invested in understating their experiences. Hence, care ethics brings attention to the central idea of the relational self which entails the interconnectedness among humans and therefore, the “interdependency and vulnerability of human existence” (Maeckelberghe, 2004, p. 319). Maeckelberghe adds that this view of relationality also entails an orientation and sensitivity to understanding the realities of other people and the contexts in which these realities are constructed. Feminist care ethics, therefore, highlights the importance of a relational approach to the achievement of social justice, rather than the neoliberal view of justice that is based on preserving individual rights (Okano, 2016; Woods, 2012).

Both CRF and feminist care ethics offered important contributions to the study. They also complemented one another to inform the research process I undertook and served to guide the generation and my analysis of data. In this chapter, I provide an account of each of the theories informing this study and explicate their contributions and how they complement one another.

3.2 Critical Race Feminism (CRF)

CRF, an offshoot of critical race theory (CRT), emerged at the end of the 20th century through the work of distinguished scholars, such as Derrick Bell, Kimberlé Crenshaw, Richard Delgado, and Patricia Williams, “... as a race intervention in feminist discourse” (Wing, 2003, p. 7), and to interrogate the many interlocking systems of oppression experienced by women of color⁹. CRF “operates at the nexus of race and gender” (Berry, 2014, p. 6), and employs the basic

⁹In my application of CRF, I use the term “racialized” women instead of “women of color”, “people of color”, or “visible minority” because the racialization of Muslims is not based on skin color but on a religious identity (Tariq, 2020). Also, ‘racialization’ refers to a process that is imposed by others, and where “racialized groups are characterized by forms of experience they have undergone and a sociohistorical identity that they possess because of the false attributions to them” (Blum, 2010, p. 300). This term also reflects an awareness of the social construction of such racial classifications and that such construction is questioned and is resisted. My intention is also to bring focus on race as a social construct that encodes and reproduces unequal relationships that has shaped the lived experiences and historical realities of racialized people by

tenets of feminist and critical legal and race paradigms while simultaneously addressing the limitations of each perspective (Wing, 2003). It aims to address the limiting focus on the binary of Black and White and to challenge the notion of sisterhood and global feminism by arguing that the intersections of gender, race, class, and other axes of difference uniquely impact the lives and the experiences of women of color (Harris, 2003; Wing, 2003). Still, CRF draws on feminism to distinguish the experiences of women of color from those of men of color, which also makes CRF a feminist intervention within CRT (Wing, 2003).

CRF shares the main tenets of CRT (Kim, 2016), but it occupies its own developed theorizing space. As with CRT, CRF focuses on the issues of power relations and oppression from within a feminist paradigm by examining how race and racism influence social structures, practices, and discourses that affect the lives of women of color with the main goal of eliminating all forms of oppression experienced by them (Berry, 2014; Yosso, 2005). Another shared tenet between CRT and CRF is their rejection of the concept of color-blindness and White neutrality that are deeply embedded within society and allow for racism to thrive without critical examination (Berry, 2014). Therefore, critical race feminists depict the current state of racism and the hidden powers within racial discrimination and expose White privilege as a means to power, domination, and self-interest (Delgado & Stefancic, 2013). They argue that systemic oppression can only be understood within the contexts that produce and enforce power relations that privilege some while subjugating others (Clark & Saleh, 2019; Verjee, 2012; Wing, 2003). Based on this argument, CRF provides a useful lens to examine “how racism is normalized and embedded in institutional cultures, policies, procedures, and practices” and to expose the

assigning them a racial identity and placing them on a racial hierarchy where they occupy an inferior place to Whites who are at the pinnacle (Applebaum, 2011).

neoliberal myth of color-blindness that maintain inequities and the “racialized and gendered social hierarchies” (Henry et al., 2017, p. 13). Further, CRF examines how the hegemony of Whiteness as the accepted norm shapes the construction of discourses, assumptions, and stereotypes that infiltrate the institutional cultures, supporting the unconscious biases and the exclusion of minorities (Delgado & Stefancic, 2013). CRF’s attention to the contexts deepens the understanding of the experiences of Muslim nurses who wear a hijab by situating these experiences within the historical, sociopolitical context of Canada and within the institutional context of Canadian nursing, and their multilevel interplay in shaping the experiences of the nurses.

CRF challenges social injustices and aims to eliminate persistent inequities (Few, 2007; Parsons & Plakhotnic, 2006). Montoya (2006) affirms that the goal of CRF is to bring out the voices of women of color and to engage in the process of dismantling the barriers created by the intersections of their gender, race, and class. As a theoretical framework, CRF provides “the tools for challenging subordination at its core and understanding how various oppressions are connected and interrelated - setting the stage for truly transformative change in our society” (Onwuachi-Willig, 2006, p. 736). To include the voices of women of color, CRF challenges the notion of sisterhood and global feminism by arguing that the intersections of gender and race uniquely impact their lives and experiences (Hua, 2003; Wing, 2003). It is important to note that over the years, the application of CRF has expanded to address the racialized experiences of women and other marginalized groups (Yosso, 2005).

CRF engages in resisting and dismantling racism through the construction of counter-narratives that illuminate the voices of those who are oppressed, and their voices are silenced. Critical race feminists argue that counter-narratives offer an alternative to the dominant group’s

perspective (Harper et al., 2009), disclosing an alternative reality that differs from the reality offered by master-narratives (Delgado, 1989, 2000; Wing, 2003). In this sense, CRF aids the examination of how hegemonic power dynamics are reinforced and negotiated by Muslim nurses who wear a hijab. Hence, I utilized CRF to ground the understanding of the stories of Muslim nurses who wear a hijab to unveil the power relations and power structures that produce and reproduce anti-Muslim racism within Canadian nursing. It also offers a starting point from which the impacts of the intersections of the nurses' multiplicative identities are analyzed (Berry, 2010).

Stories are a powerful means to communicate and understand experiences. Delgado (1989) eloquently describes the power of stories:

Stories humanize us. They emphasize our differences in ways that can ultimately bring us closer together. They allow us to see how the world looks from behind someone else's spectacles. They challenge us to wipe off our own lenses and ask, "Could I have been overlooking something all along?" Telling stories invests text with feeling, gives voice to those who were taught to hide their emotions. Hearing stories invites hearers to participate, challenging their assumptions, jarring their complacency, lifting their spirits, lowering their defenses (p. 2440).

Stories have long been an effective tool to document the violence and oppression perpetrated by the colonizer and to resist it. Indigenous peoples analogized their experiences with the colonizer through stories that also held within them their epistemic traditions, philosophies, and theories, which is in stark contrast to the neoliberal notion that stories are "depoliticized acts of sharing" (Sium & Ritskes, 2013, p. V). Sium and Ritskes push against this diluted

construction of stories and their function within neoliberal thought in which stories are presented as a form of entertainment. They stress the need to see stories as powerful acts of decolonization, providing a powerful approach to deconstructing colonial ways of knowing and to reconstructing alternatives to them. Similarly, Delgado (1989) calls upon the members of the dominant race to listen to all kinds of stories. He argues that stories influence the oppressors by disrupting their own privilege and their construction of a reality that is rational, comforting, and favorable to them. Listening to the stories of the oppressed engages oppressors and unsettles their complacency. Stories are also powerful for those who tell them: they are a source of self-preservation and liberation (Delgado, 1989). Informing this study by CRF brings amplifies the voices of Muslim nurses who wear a hijab and highlights the utility of their stories in enacting transformational change within nursing.

Finally, CRF is grounded in the concepts of anti-essentialism (Grillo, 1995; Harris, 1990, 2003) and intersectionality (Crenshaw, 1991). Grillo (1995) argues that both anti-essentialism and intersectionality ask that we “define complex experiences as closely to their full complexity as possible and that we not ignore voices at the margin” (p. 22).

3.2.1 Anti-Essentialism

CRF is anti-essentialist in nature as it rejects the monolithic voice that speaks for all women and offers a critique of essentialism within the feminist discourse, but strategically views race, class, gender as a starting point to unravel the complexities of racialized women (Grillo, 1995; Verjee, 2012). Essentialism, as defined by Grillo (1995), is “the notion that there is a single woman's, or [B]lack person's, or any other group's experience that can be described independently from other aspects of the person-that there is an ‘essence’ to that experience” (p.

19). Nonetheless, the purpose of gender, racial and other forms of essentialism is to reduce the experiences of racialized women to an “addition problem” by fragmenting their experiences into race and gender and ignoring their voices while effectively making White women the epitome of all women (Harris, 2003, p. 34). In this respect, this essentialized voice reflects the experiences of White, middle and upper-class women while professing to be inclusive of the experiences of racialized women (Wing, 2003). Though essentialism is not inherently racist, it can foster unconscious racism through silencing the voices of racialized women while imposing stereotypical assumptions on them. Further, essentialism overlooks race and undermines racism, in which “racism that is acknowledged only in brackets quietly emerges in the feminist theory itself-both a cause and effect of creating ‘Women’ from White women” (Harris, 2003, p. 37). Therefore, Collins (1994) warns that essentialized thinking within feminism perpetuates social inequities and exclusion and reflects the particular social locations of those who are privileged. A subsequent effect of essentialism is that the experiences of racialized women are fragmented, “as those who are ‘only interested in race’ and those who are ‘only interested in gender’ take their separate slice” (Harris, 2003, p. 34). Harris adds that as long as essential feminists continue to search for the essence of gender and race, racialized women “will never be anything more than a crossroad between two kinds of domination, or at the bottom of a hierarchy of oppression” (p. 35).

The study of race and gender from an essentialist stance has “promoted binaries of superiority or inferiority, of the colonial subject or women as inferior, and such discourses were vital for the perseverance of patriarchal and colonial hegemony” (Eide, 2016, p. 1). Essentialism succeeds in promoting binaries through the assumption that groups hold one or several characteristics or qualities that define all the members of the group and thus, reducing the

individuality and complexities of people. Spivak (1988) coined the term ‘strategic essentialism’ to refer to temporarily suspending differences among a group to achieve the group’s political goals. While it is critical that we need to take a stand against essentialism, essentialism itself can be temporarily used as part of the political strategies of racialized people to push for social justice (Spivak & Grosz, 1990). Wing (2003) contends that critical race feminists are, to a certain degree, essentialists for they speak of the experiences of Black women, Muslim women, and so on, as if these women hold an essential voice that represents the experiences of each respective group. Hence, I agree with Grillo (1995) that essentialism is “not always a bad thing; however, unconscious, self-protective, self-advancing essentialism is” (p. 21). It is necessary, at times, to be strategically essentialist while acknowledging the complexities of each group and the distinctiveness of their experiences.

3.2.2 Intersectionality

Kimberlé Crenshaw (1989), a Black feminist and a legal scholar, coined the term intersectionality, in which she argues that Black women are discriminated against in ways that do not ascribe to the effects of racism or sexism separately, but as a result of the intersections of their gender and race. Intersectionality emerged as a response to the second wave of feminism, which was criticized for ignoring differences and approaching the understanding of multiple and simultaneous oppressions as the sum of the different forms of oppression. Indeed, intersectionality has become a central tenet of feminist thinking and the most valuable contribution of feminist theory (McCall, 2005), as it moved feminism beyond the exclusive focus on gender and its relation to oppression experienced by women to accounting for the intersections of multiple axes of difference (Singh, 2015). In this study, because Muslim nurses who wear a hijab are both racialized and gendered, their experiences cannot be fully understood

or described without using the lens of intersectionality. Intersectionality emphasizes the interlocking systems of power, including sexism, racism and beyond, in shaping the experiences of the nurses.

As articulated by Collins and Bilge (2016) there are many variances in the different meanings of intersectionality, but within this study intersectionality is defined as

... a way of understanding and analyzing the complexity in the world, in people, and in the human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other (p. 2).

This definition points to a general agreement on how intersectionality is understood and to the potential intersectionality holds as a lens to explore the intersectional experiences of racialized women. Moreover, the use of intersectionality can take many forms (e.g. as a framework, analytical approach), as it continues to evolve. Therefore, generalizations about intersectionality based on a certain case or the experience of one group risks "missing the process of discovery that underlines how people actually use intersectional frameworks" (Collins & Bilge, 2016, p. 31). Further, intersectionality is used in conjunction with CRF to allow for a deeper examination of the experiences of racialized women and the impact of their multiple marginalized identities on their experiences.

Intersectionality goes beyond the multiplication of social identities (gender, race, class, and religion, to mention a few) to provide an approach to understanding how certain identities and conditions exist within structures of power (Crenshaw, 1989). It allows for the study of the relationship between power and identity in that it examines interplay between power structures and the ways they produce social inequities that affect groups and people differently. Therefore, critical race feminists recognize power relations that are embedded within socially constructed identities, which entails a deeper examination of the experiences of oppression and discrimination while accounting for the contexts (Anderson & McCormack, 2010). Within intersectionality, social identities are not mutually exclusive or operate separately from one another. Gender based discrimination, for example, is not identical to racial discrimination and neither of these may be similar to the impact of religion. Rather, gender and race compound each other in certain ways to produce an effect that is greater than the sum of the two (Solanke, 2009).

Intersectionality challenges the reductionist notion of placing experiences into categories of gender, race, and class, for people are not separately gendered, racialized, or classed. Therefore, it rejects the additive approach to understanding social locations while takes on the notion that people are uniquely positioned at the intersections of multiple axes of identity (McCall, 2005). It also interrogates the complex and interlocking power relations that produce social locations, and “seeks to understand what is created and experienced at the intersections of axes of oppression” (Hankivsky, 2014a, p. 225). Hankivsky (2014b) asserts that categories and their importance are not predetermined and therefore, when using intersectionality to analyze social problems, categories of difference and their importance must emerge from the analysis. However, in this study, I strategically use gender, race, and religion to examine the experiences of nurses who wear a hijab across multiple intersecting social categories following McCall’s

(2005) intercategorical complexity approach to intersectional analysis in which researchers “provisionally adopt existing analytical categories to document relationships of inequality among social groups and changing configurations of inequality along multiple and conflicting dimensions” (p. 1773). Therefore, this approach begins from the observation of the relationship between a socially constructed group and inequities while positioning this relation at the centre of the analysis. I used categories pragmatically and I maintained a critical stance towards categories by focusing on the relational process in which they are produced, reproduced, and maintained while paying close attention to emerging categories.

Intersectionality is inherently critical; it critiques the status quo of knowledge, existing theories, and methodologies in relation to social inequities (Collins & Bilge, 2016). This critical orientation is reflected in the core objective of intersectionality to “probe beneath the single identity to discover other identities that may be present and contributing to a situation of disadvantage” (Yuval-Davis, 2006, p. 204). Individuals and communities do not occupy a subordinate position by virtue of some inherent property (e.g., their race or religion), but rather acquire this position as the outcome of socio-historical and political processes, and thus, intersectionality shows simultaneous experience of power and privilege dependent upon the contexts. Further, Collins and Bilge explain that being critical requires “working at the intersections”, which implies that intersectionality is “not simply a method of doing research but is also a tool for empowering people” (p. 37).

Intersectionality and CRF converge to interrogate power relations. Collins and Bilge (2016) argue that power within an intersectional framework is “better conceptualized as a relationship, as in power relations, than as a static entity. Power is not a thing to be gained or lost... Rather, power constitutes a relationship” (p. 28). While CRF places power relations at the

center of the discourse on gender, race, class, and other forms of social oppression (Verjee, 2012), intersectionality allows for the understanding of “power relations through a lens of mutual constructions” (Collins & Bilge, 2016, p. 26). Collins (2019) thus draws attention to the construct of relationality in that systems of power, such as gender, race, class, religion etc. “are interdependent and mutually construct one another” (p. 44). Collins explains the importance of understanding relationality, in that it shifts the focus on categories and their essentialist qualities to accounting for the processes that connect them and the meaning they gain through such relations. Collins and Bilge (2016) speak to the same notion that socially constructed identities are shaped by many factors and in many diverse ways, where “race, class, gender, sexuality, disability, ethnicity, nation, and religion, among others, constitute interlocking, mutually constructing or intersecting systems of power” (p. 27). In this vein, intersectionality opens up nuanced understandings of how social categories are related and/or inform each other. Also, this allows for a deeper analysis of social groups as non-homogenous rather than possessing a universal, singular or essentialist identity and by rejecting the notion of a monolithic experience that speaks for all members of the group. At the same time, intersectionality, as with CRF, does not do away with essentialism and categories as it allows for strategic essentialism to be used for social justice aims (Rice et al., 2019). Drawing on intersectionality, this study shows that not all Muslim nurses who veil faced the same forms of racism or sexism and that some, as in the case of Black Muslim nurses, have experienced oppressive structures more than others.

As I explain in the next chapter, I used intersectionality in this study as an analytical lens which assisted me in understanding the role of religion along with gender and race on the experiences of nurses who wear a hijab and in revealing how power structures and power relations within gendered and raced institutional settings (e.g., nursing education and practice)

operate to produce and maintain privilege and vulnerability (Hankivsky, 2012). Intersectional analysis moves beyond the individual focus to consider multi-level root causes of social problems (Anthias, 2012) (e.g., anti-Muslim racism), including settler colonialism, neoliberalism, and racism in the Canadian healthcare system and nursing. The use of intersectionality as an analytical lens, and though I took on an intercategorical complexity approach to examine how gender, race and religion have shaped the experiences of the nurses, allows the emergence, through the analysis, of new categories (speaking with non-native accent, the perception of the nurses (in)capabilities, and class) and the ability to examine their complex relationality to the predetermined socially constructed differences in experiencing anti-Muslim racism. Intersectional analysis meant that I paid critical attention to not only the oppressive experiences of nurses who wear a hijab but also to explore and document their agency and their resistance.

3.3 Care Ethics

Care ethics is a theoretical framework that endorses care as a key feature of human relations and interactions. The values embedded within care ethics are not new nor exclusive to Western philosophies. However, the work of feminist theorists in the last two decades brought care to the center of Western political philosophy. The value of care ethics in its prioritization of the human condition “opens up new ways of seeing human beings, their social problems, and their needs, and how these needs have been addressed (Hankivsky, 2004, p. 2). In this vein, care ethics gives new meanings and importance to human differences that arise from gender, race, class, and other axes of difference. Because of its sensitivity and responsiveness to individual differences, care ethics provides new perspectives on understanding experiences with

discrimination and oppression (Hankivsky, 2004, p. 2). Hankivsky who discusses the feminist project called care ethics explains that:

[care ethics] opens the door for the proper identification and critical examination of those wider structures that create relations that result in exclusion, marginalization, suffering, and harm understanding people's lives, but, significantly, being able to honestly appraise and recognize conditions of inequality, disadvantages, and discrimination, can be especially beneficial for responding adequately and responsively to gender, racial, ethnic, cultural, and class differences and oppression (p. 24).

The main intention of care ethics is to uncover social injustices that otherwise might remain concealed by challenging objective notions of fairness, refuting the neoliberal assumptions of equality, and by affirming the role of the social contexts in systemic discrimination. In this vein, some care ethics theorists converge with intersectional and race feminist theorists who support the notion that social locations and the experienced disadvantages resulting from them are often covert and call for the need for the critical examination of powers relations that maintains them (Crenshaw, 1990; Wing, 2003).

The evolution of care ethics is captured in the work of first and second generation theorists. The first generation of care theorists, such as Gilligan (1982) and Held (1993), linked care to gender, either explicitly or implicitly, where care as moral reasoning emerged from women's experiences of caring, mothering, and nurturing, and through the assumption that women are more likely to be in the position of caring than men (Hankivsky, 2004). The gender limitation of the conceptualizing of care ethics has been criticized by scholars who argue that there is nothing exclusively feminine about care and that the unidirectional conceptualization of

care ethics makes it impossible to apply the paradigm to the public sphere and its institutions. Among the criticisms of the gendered focus of care is that it risks further oppressing women by reinforcing stereotypes and contributing to the essentializing of their experiences. Finally, first generation theorists separated care ethics from justice under the claim that care ethics is superior to justice, as it constitutes a wider moral framework where social justice can be attained (Hankivsky, 2004).

Second generation care theorists, such as Tronto (1993) and Sevenhuijsen (1998), addressed these criticisms by centering care to all human life and activities and providing the basis of how the ethics of care and justice can interact and intersect. The work of Sevenhuijsen and care theorists in this wave expanded care ethics beyond its limited beginnings, as their conceptualization of care is rooted in relational ontology that acknowledges the codependency among people (Hamington, 2015; Raghuram, 2019). The relational conception of care ethics expands the understanding of the moral agents to include not only individuals, but also groups, institutions, and nations (Pettersen, 2011). These relations transcend the private-public and individual-collective boundaries to capture the asymmetrical and power imbalanced interaction among groups and between individuals, groups, and institutions. In this way, the starting point of care ethics is the social ontology of relationality, in which attentiveness, respect, mutuality, and trust are fundamental to caring (Tronto, 1993). The relational ontology of care ethics rejects the neoliberal notion of autonomous individuality (Schu-Ching, 2016), attends to the impacts of the contexts in which people are situated (Hankivsky, 2004; Tronto, 1993), and provides the potential for care ethics to shift status quo through social relations and sensitive attention to power structures. As asserted by Dalmiya (2002), the conception of moral agents as related allows care ethicists to critically analyse relationships and the harm that some might inflict.

Caring for one another is an important democratic activity and is a moral orientation that involves caring for and about others. Care ethics stands in contrast to the neoliberal values of individualism and independence by recognizing the interdependence between human beings and transcending the lines between public and private spheres. Care ethics theorists, therefore, critique the dichotomous construction of independence and dependence and replace it with the concept of interdependence to articulate the links between caregiving, care needs, and the larger social systems of care in which individuals are situated (Hankivsky, 2004). Therefore, care ethics opposes the neoliberal ethics that do not recognize the notion of public good or public interest (Yuval-Davis, 2011); it contests the dominance of neoliberal justice-based perspectives that conceptualize human beings as independent rather than interdependent and employs abstract universal principles without attending to the role that contexts play in shaping experiences (Hankivsky, 2004). Hence, care ethics is attentive to the unbalanced power structures across gender, sexuality, race, ethnicity, class, migration status, and disability, and is directed to enact social change (Bourgault & Robinson, 2020).

Nursing and care are intertwined, which is often implied within the discipline by the assertion that caring defines nursing (Woods, 2011). Indeed, several philosophers and theorists grounded in the field of nursing have maintained that caring is the philosophical, theoretical, practical, and ethical foundation of nursing, and that care ethics is an integral and essential aspect of nursing practices (Benner, 1997; Watson, 1990). The dominance of the notion of care in nursing and its being women dominated discipline have resulted in a considerable degree of enthusiasm for the adaptation of care ethics (Woods, 2011). However, care ethics is not uniquely feminine, as men also may exhibit strong tendencies to care, for “factors of social identity, such as ethnicity, class and sociality influence the correlation of gender to care” (Green, 2012, p. 2).

In this study I applied the feminist model of care ethics proposed by Hankivsky (2004), which is informed by the work of care theorists and is based on the moral principles of contextual sensitivity, responsiveness, and attentiveness to the consequence of choice. These principles of care ethics can be “flexible, able to accommodate particular issues and situations, and be open to different processes of analyses and outcomes” (Hankivsky, 2004, p. 99). Hankivsky asserts that these principles have the capacity to capture the aims and objectives of care ethics. From a care ethic perspective, people are shaped by their historical social, political, economic, and geographic contexts. Therefore, practices grounded in care ethics are contextually sensitive, requiring attentiveness to the influences of axes of difference. The principle of contextual sensitivity, as argued by Hankivsky, allows for the critical examination of marginalization and oppression through capturing the processes that produce inequities and can no longer be ignored.

Responsiveness is the second principle and is a prerequisite for attaining contextual sensitivity. Tronto (1993) asserts that responsiveness “signals an important moral problem within care: by its nature, care is concerned with conditions of vulnerability and inequality” (p. 134). She further argues that responsiveness does not equate reciprocity, but rather provides another method of understanding vulnerability and inequality (Zembylas et al, 2014). Thus, responsiveness goes beyond superficial empathy or insincere efforts to understand the positions of others based on our own experiences (Barnes & Brannelly, 2008; Hankivsky, 2004). Caring entails continued responsiveness to ensure needs are met and to examine the structures and conditions leading to these needs. Hence, responsiveness requires serious and ongoing examination of the perspectives of those who experience inequities, which requires a commitment to active listening and to providing a safe place for people to share their experiences

of Othering in order to shift the focus from differences as the problem to “the social constructs that render differences problematic” (Hankivsky, 2004, p. 36).

Responsiveness is congruent with the narrative approach to capturing the experiences of those who are oppressed and offers a critical perspective of their world. Responsiveness as a main principle of care ethics offers an opening to include the voices and perspectives that are traditionally not heard, which broadens the understanding of how “social and institutional structures and the relations that develop within these contribute to exclusion, oppression, and marginality” (Hankivsky, 2004, p. 37). Therefore, this principle of care ethics is congruent with value and the importance of counter-narratives as an approach for enacting social justice. However, Hankivsky acknowledges the risk of further essentializing such experiences but argues that the principle of responsiveness is aligned with the premise of the social construction of experiences. Thus, narrating experiences potentiates the illumination of how social locations lead to Othering. This possibility, as argued by Hankivsky, provides the grounds for a critical dialogue that accounts for the contexts and is based on the relational interdependence of humans, which are absent from the liberal contextualization of social justice. Thus, the counter-narrative of Muslim nurses who wear a hijab can be used to achieve social justice by disrupting inequitable power structures in nursing, bringing their voices to policy, and by challenging the “layers of ... racism, sexism, classism, and other forms of subordination” (Solórzano & Yosso, 2002, p. 28). These advances stimulate critical dialogue and aim to disrupt hegemonic practices sustaining racialization within nursing while promoting the larger aims for social justice (Clark & Saleh, 2019). Indeed, the inclusion of those who are oppressed by social injustices works to transform structures of dominance into more equitable ones and to cultivate the role of oppressed peoples as agents of social and political change.

The third principle of the model of care ethics is attentiveness, which encapsulates the consequences of choice, a departure from the normative orientation of the neoliberal individualistic interpretations of human nature; it offers an understanding of the interdependence of humans that stands in contrast to a notion of justice that does not consider the direct or indirect impacts of actions on those around us (Hankivsky, 2004; Maeckelberghe, 2004). Care ethics calls for understanding and evaluating the connections between our choice of actions and how they impact others and emphasizes the potential harms that might be inflicted by our chosen actions and the ways they can be elevated. Hankivsky argues that operationalizing the principle of attentiveness to the consequences of choice necessitates a commitment to the elimination of all inequities. The failure of multiculturalism to ensure inclusivity and integration of Canadian Muslim communities, evident in how they continue to be subjugated through systemic and structural racism since 9/11 and during the COVID-19 pandemic, demonstrates the critical need for care ethics that is responsive, sensitive, and attentive to enact social and political transformational change to address the care crisis and to consequently, enhance individual and collective well-being (Hankivsky, 2014a).

Care ethics complements CRF by highlighting the interdependence between human beings and the importance of the larger social systems in which individuals are situated, thus facilitating new meanings and importance to human differences that arise from gender, race, class, and other axes of differences (Hankivsky, 2014a). Moreover, because of its sensitivity and responsiveness to individual differences, care ethics enables nuanced understandings of the individual experiences of Muslim nurses wearing a hijab with Islamophobia. Further, informing this study by care ethics lends a lens that challenges the neoliberal values of fairness, individualized responsibility, and freedom of choice that dominate Canadian social, economic,

and political discourses. These neoliberal values continue to dilute and obscure power relations that produce oppression and discrimination and perpetuate racism. Care ethics offers a valuable lens into examining democratic covert racism within the Canadian healthcare system and the discipline of nursing. Care ethics is attentive and sensitive to the contexts in which oppression is enacted. Informing this study by care ethics expanded the focus on the contexts beyond the healthcare system and the discipline of nursing to include the historical and sociopolitical context in which the experiences of nurses who wear a hijab are constructed against.

These principles of care ethics guided my activities and my stance throughout the research process. They affirmed the interdependence between myself and the participants, our co-construction of meanings, and the need that I actively listen and provide a safe space for participants to share their stories. Finally, informing this study by the theory of care ethics centered the role of the contexts into all aspects of the research process.

In summary, I applied CRF to examine the experiences of nurses who wear a hijab as these experiences are shaped by their gendered and racialized identities and how they are constructed through powerful and circulating master-narratives. CRF, therefore, focuses on the interlocking systems of oppression that shape the experiences of the nurses with Islamophobia. CRF also brings anti-essentialist and intersectional lenses which highlights the uniqueness of the experiences of the nurses and illuminates their voices while allowing for the understanding of religion as an identity and how it intersects with other axes of difference to shape the experiences of the nurses. Finally, I brought care ethics, using the model proposed by Hankivsky (2004) to allow for the contextual understanding of the experiences of the nurses while remaining attentive to the unbalanced power structures with the commitment to the elimination of inequities and enacting social justice. Below is a model that represents how I employed CRF and Care ethics to

guide the understanding and the analysis of the experiences of Muslim nurses who wear a hijab (Figure 1).

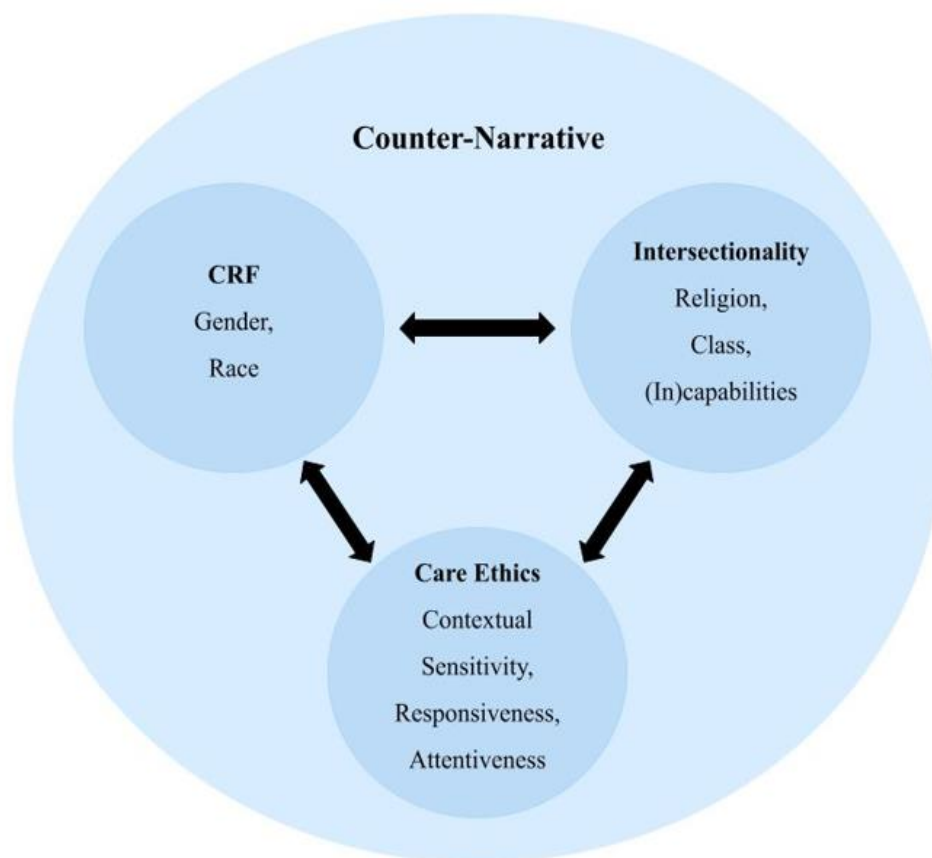


Figure 1: The Application of Critical Theoretical Approaches

3.3.1 Intersectionality and Care Ethics

Hankivsky (2014a) contends that care ethics can be enhanced by applying the concept of intersectionality. Indeed, care ethics is not inherently intersectional as even the most complex versions of care theories prioritize gender and gender-based power relations, with the addition of other axes of difference. While care ethics theorists include a focus on “the feminization and racialization of care, they tend to mask the historically rooted ties and mutually constituting processes and patterns of broader range of oppression” (Hankivsky, 2014a, p. 253), which falls

short from interrogating power relations that construct differences. Hence, a logical approach is to enhance care ethics through critical engagement within intersectionality, as the two theoretical perspectives share many philosophical underpinnings (Hankivsky, 2014a). Further, both care ethics and intersectionality have their roots in social constructionism, evident in their relational ontology, attentiveness to the contexts, commitment to social justice, and in their shared view of the social construction of differences.

Informing care ethics by intersectionality enhances care ethics in two main ways. First, Hankivsky (2014a) claims that the marriage ensures the examination of social locations and the move beyond the homogenizing inclination of care theorists to group people into categories. An intersectional lens into care ethics avoids the reduction of the complexities of social life that is usually guided by the flawed assumption of shared experiences and care needs among each group. Scholars and theorists usually follow “a priori analytic prioritization”, with gender as the most significant category; an approach that intersectionality rejects (Hankivsky, 2014a, p. 256).

The second enhancement to care ethics that can be gained from bringing an intersectional perspective is the move from gendered manifestations of power to intersecting systems of power (Hankivsky, 2014a). As explained earlier, though there are references to the racialized and gendered aspects of care, gender continues to be the focus of care theorists as the most relevant category of difference, which results in focusing on gendered aspects of power. This is not to negate gendered based powers and the role of patriarchy, but to stress the need for examining power relations through an intersectional lens that reveals the interacting forces of power and structures, including but not limited to, patriarchy. Therefore, an intersectional lens would bring a paradigm shift on the conceptualizing of power within care ethics by moving the focus to the

“intersecting systems as simultaneous and inextricably linked, rather than simply interpedently significant” (Hankivsky, 2014a, p. 260).

In this chapter, I grounded the exploration of the experiences of Muslim nurses who wear a hijab within the CRF and care ethics. I also highlighted the contribution of each theory in informing this study and in framing and enriching the understanding of the nurse’ experiences. Now I move to discuss narrative inquiry as a research methodology that guided the recruitment strategy, data generation, and data analysis.

Chapter 4: Methodology

4.1 Introduction

As a methodology, narrative inquiry is an action plan that guides the process of data collection, analysis, and interpretation (Stitt & Winsor, 2014). It requires researchers to “recognize and embrace the subjective reality inherent in the process” (Wang & Geale, 2015, p. 197). Thus, it is concerned with illuminating the meanings of experiences and not with arriving at an objective context-void truth (Bailey & Tilley, 2002). Further, narrative inquiry is a methodological approach that allows for a deep understanding of socially constructed differences and its reliance on storytelling serves to amplify the voices of nurses who wear a hijab as a counter-narrative to oppose and resist the colonial Orientalist master-narratives about them.

4.2 Narrative Inquiry

Grounded within the ancient tradition of storytelling (Bailey et al., 2013; Clandinin & Rosiek, 2007), narrative inquiry is increasingly recognized within the qualitative research paradigm as a valued methodology where stories are essential to understanding the human experience (Kim, 2016). Narrative inquiry is located within the interpretive paradigm, “with theoretically, philosophically diverse approaches and methods, all revolving around the narratives and stories of research participants” (Kim, 2016, p. 5). The ‘interpretive turn’ as a response to the inability of the positivist ontology and epistemology to capture the human experience led to a growing interest in narrative approaches (Riessman, 2008; Spector-Mersel, 2010). This turn to interpretivism renewed the value of narratives as alternative methods of inquiry to capture experiences and to amplify the voices that have been silenced (Spector-Mersel, 2010). Therefore, the stories of the narrative approach allow participants to share their

experiences without externally imposed constraints, thereby giving voice to those who are often silenced or marginalized (Wang & Geale, 2015).

Fundamental to conducting narrative inquiry is the centrality of ‘narrative’ and ‘story’. Though narrative and story are often used interchangeably, some argue that they are analytically distinguished, where stories are told and people tell their stories to be heard while a ‘narrative’ is defined as deriving from the analysis of the stories (Frank, 2000; Riley & Hawe, 2005). East and colleagues (2010) define stories as “research participants’ personal accounts of experiences” and narrative as “structured and formal accounts containing researcher addition and omissions” (p. 19). Comparatively, Kim (2016) differentiates between the two wherein “... a story is a detailed organization of narrative events arranged in a (story) structure based on time although the events are not necessarily in chronological order” (p. 8). Therefore, a story is composed of narratives, making stories a “...higher category than narrative as the latter constitutes the former; and they are deeply intertwined. Narratives constitute stories, and stories rely on narratives” (Kim, 2016, p. 8). Further, Connelly and Clandinin (1990) explain this distinction between a story and that of a narrative by referring to the phenomenon as ‘the story’ and the inquiry as the ‘narrative’, meaning that “people by nature lead storied lives and tell stories of their lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience” (p. 30). Most importantly, the focus should remain on “... the act the narrative reports and the moral of the story” (Riessman, 2008, p. 62). Though stories are somewhat distinguished from narratives, the term ‘narrative’, as argued by Strate (2014) is the human activity of telling stories, which is the reason that, throughout, this text I followed Riessman (2008) in adopting the “contemporary conviction” of using ‘story’ and ‘narrative’ interchangeably (p. 7).

Riessman (2008) states that “narratives are strategic, functional, and purposeful” (p. 8). They enhance our understanding of experiences as they take place in the world, making it relatively insignificant whether parts of the story are held or altered (Bell, 2002). In this respect, narrative inquiry goes beyond valuing stories to exploring the assumptions that underscore them and “the social, cultural, and institutional narratives within which individuals’ experiences [are] constituted, shaped, expressed, and enacted” (Clandinin and Rosiek, 2007, p. 42). Findings within a narrative approach to inquiry are expressed through the construction of a narrative by ‘re-storying’ the stories shared by participants. Counter-narratives are “the narratives that arise from the vantage point of those who have been historically marginalized” (Raúl, 2014, p. 1), to speak against and challenge the accepted truths with the aim of destabilizing master-narratives (Romeo & Stewart, 1999). They challenge White privilege, give a voice to those who are discriminated against, and discredit the notion of color-blindness as a base for covert racism (Delgado & Stefancic, 2013). Counter-narratives “... are not fictional, but instead grounded in actual life experiences. They can be presented in the form of a composite narrative” in which researchers create socially contextualized and located characters that present and foreground the combined experiences of research participants (Patton & Catching, 2009, p. 716). Composite narratives have the ability to weave together multiple situated accounts and to present them as whole stories (Willis, 2019). They also align with the ontological underpinning of critical race feminism where counter-narratives are powerful means to integrate and dismantle racism (Patton & Catching, 2009; Solórzano & Yosso, 2002). The use of composite narrative is also congruent with Riessman’s (2008) method of analyzing narratives holistically.

Therefore, in this study, I chose to present the counter-narrative of nurses who wear a hijab in three composite narratives that I constructed from the stories shared by ten nurses. A ‘composite narrative’ refers to a technique where several interviews are combined and presented in one or more individual stories that are linked by a shared purpose or identity among research participants (Willis, 2019). To maintain the power and strength of the nurses’ personal stories, I constructed these composite narratives in the first person with the intention that they act as a vehicle to communicate the nurses’ experiences. I also chose to present the findings in this way based on my ethical obligation and commitment to protect the anonymity of the nurses. It is also important to make clear that the three constructed composite narratives also capture the stories of nurses who are racially diverse and practice in varied nursing settings. I will further elaborate on these reasons later in this chapter.

Narrative inquiry does not privilege one data collection method (Riessman, 2008; Trahar, 2009). Rather, it makes use of stories as a source of data, including “written and oral, personal and collective”, big and small stories, stories that have already been told or have only been told during research (Spector-Mersel, 2010, p. 213). While data collection methods that are most congruent with narrative inquiry include storytelling, journaling, and interviews, interviews are the most used method in narrative studies (Stitt & Winsor, 2014).

While using the interviewing method, it is vital that researchers acknowledge the influence of their presence, actions, and interactions with research participants on the stories being told during the interviewing process (Spector-Mersel, 2010). Attending to the influence of narrative researchers on the research process makes it a reflexive methodology that requires narrative researchers to engage in continuous self-examination, exploration, and explanation of how they influence their research (Clandinin & Caine, 2013, p. 171; Dowling, 2008). Lindsay

and Schwind (2016) describe narrative inquiry as engaging in an “inquiry puzzle” that makes the researcher a co-participant (p. 14). Respectively, researchers become a part of the experience, as they “observe, listen, and live alongside [research] participants, which allows for a deeper insight into the research phenomenon” (Lindsay & Schwind, 2016, p. 15). Narrative inquiry, therefore, allows for co-constructing knowledge that is particular and context bound, as researchers take part in a process of re-storying participants’ stories, reflect on their own positioning and how it influences the told stories, represent the complexity and richness of the participants’ experiences, and discover the deep, multiple layers of these experiences and the contexts shaping them (Bell, 2002; Wang & Geale, 2015). In this way, the co-construction of knowledge also functions as an approach to addressing power imbalances between the researcher and participants (Karnieli-Miller et al., 2009).

I used a qualitative design drawing on Riessman’s (2008) approach to narrative inquiry to guide this study. Among other tenets, Riessman acknowledges the importance of the contexts and the personal influence the researcher has on the analysis, which I remained attentive to through reflexivity. Using this approach for data generation and analysis has allowed me to critically investigate and interpret the construction of meaning within each story and across stories.

4.3 Sampling and Participant Recruitment

4.3.1 Sample Size

Determining sample size in qualitative research is not a straightforward process. Deciding the sample size a priori remains unsettled in the literature, with some arguing that it is incompatible with the conceptual and methodological underpinnings of qualitative research (Sim et al., 2018). Some researchers suggest that the common number of participants in narrative

research is four to six (Haydon et al., 2018) and can be as small as one or two (Creswell, 2013), while others explain that sample size depends on generating sufficient in-depth, textually rich data to answer the research question (Joyce, 2015).

Determining the sample size for this study was guided by Riessman's (2008) assertion that the exact number of interviews/participants is finalized during data collection and analysis. Saturation as a concept that is often used to determine the sample size originated from grounded theory and has since, "... diffused into several qualitative communities beyond its origins" and is considered a main standard in determining sample size in qualitative inquiry (Vasileiou et al., 2018, p. 3). Data saturation, however, is a contentious concept in the qualitative methodology literature (Braun & Clarke, 2019). Braun and Clarke challenge the application of saturation by qualitative reflexive researchers who cease generating data when 'no new' themes emerge during the analysis. Instead, they assert that the interpretative judgement related to the purpose and goals of the analysis by reflexive researchers is what constitutes saturation, offering the concept of 'information power' as a useful alternative to data saturation in that there is a direct and clear relationship between the relevancy of the data and sample size (the more relevant and powerful the data, the fewer participants are needed). Attending to the tension around the concept of saturation, the sample size of this study, which accounted for ten nurses from diverse racial, educational, and practice backgrounds, was determined through the richness and the contextuality of the generated data in meeting the purpose of the study (power of information).

4.3.2 Participant Recruitment

This study was conducted across Canada to ensure the diversity of the participants. The inclusion criteria for this study were: 1) be a registered nurse, licensed practical nurse, or psychiatric registered nurse; 2) identify as Muslim; 3) wear a hijab in practice; and 4) currently

practice in Canada (in different clinical and leadership capacities). Participant recruitment was based on the established inclusion criteria and potential participants were determined to be eligible for participation through screening questions (Appendix A). The questions for inclusion were: 1) Are you a registered nurse, licensed practical nurse, or a psychiatric registered nurse? 2) Do you identify as a Muslim? 3) Do you wear a hijab in practice? 4) Are you currently practicing in Canada? And 5) As a nurse, do you practice within a clinical or leadership capacity?

I employed a variety of purposive sampling and recruitment strategies, including word of mouth and outreach through community faith-based organizations and web-based platforms. Adopting a variety of recruitment strategies ensured that the sample would include diverse nurses from across Canada. The recruitment strategy for this study evolved as the study progressed and as I needed to address challenges that rose during recruitment, mainly, adjustments to the recruitment strategy that were required due to difficulty reaching nurses who wear a hijab as a hard-to-reach population and also as a result of the COVID-19 pandemic.

At the beginning of the recruitment process, my strategy was restricted to reaching out to a number of health authorities within the province of British Columbia due to the higher numbers of Muslim immigrants in those regions. This recruitment strategy was meant to ensure the inclusion of multiple geographical and organizational contexts in which the Muslim nurses practice, as gaining diverse perspectives increase the validity of the findings. I restricted the recruitment strategy to the province of British Columbia mainly to be able to conduct face to face, in-depth narrative interviews, which function as a means for collecting data about the participants' experiences while attending to the role of the interviewer in producing data (Mishler, 1999).

Soon after I began recruiting, I was faced by two main challenges. I experienced difficulties gaining access to the nurses. The recruitment also needed to be adjusted to address challenges imposed by the COVID-19 pandemic. Nurses who wear a hijab belong to a hard-to-reach population due to the sociopolitical contexts they practice within and the gaze placed on their bodies within the public space. Shaghghi, Bhopal, and Sheik (2011) explain that faith-based communities are among the hard-to-reach populations which presents challenges to the researcher in gaining access. A hard-to-reach population is a population that is not accessible to the researcher due to its race, ethnicity, language, political affiliation, geographic location, religion, or any other characteristics (Nykiforuk et al., 2011), and where a sensitive subject matter may impact participants in unintended and potentially negative ways. The most widely used strategies to gain access to hard-to-reach populations are leaning on the insider status of the researcher and the use of snowball sampling (Mohebbi et al., 2018). As an insider, I was able to connect with leading women in the local community who advertised the study in their regular meetings and within the local mosque. Gaining access to the nurses through my insider status also resulted in recruiting participants through snowball sampling. For example, I was invited by the women leadership of the local mosque to attend a discussion on the experiences of youth/girls who wear the hijab and to present my study to the community of worshippers. After my talk, many of the women approached me and expressed their excitement about the study and their intention to “spread the word” about it.

I also expanded the recruitment strategy to include Muslim faith-based community organizations and mosques. These organizations included BC Muslim Association, The Canadian Council of Muslim Women, and Muslim Women’s Association of Canada. I contacted each of the organizations and mosques through email using contact information posted on their

webpages, explaining the study, and emailing the study's recruitment letter. After I heard back from most of these organizations and mosques informing me of their willingness to assist in recruitment, I emailed the recruitment poster to each organization and asked to have it displayed within the organization's physical building, and to post on their social media accounts as in Facebook and Twitter. This expanded the recruitment strategy and widened the geographical contexts to larger areas of BC with the plan to expand the recruitment reach.

In order to achieve maximum variation in my sample I decided to broaden the recruitment to include practicing Muslim nurses across the different Canadian provinces and to expand the reach over social media. At this point in the progression of recruitment, the ethics guidelines for conducting research that uses personal interviews as a method of data generation changed due to the new constraints imposed by the COVID-19 pandemic. The guidelines for conducting research no longer allowed for the use of personal interviews as a method of data generation changed due to the pandemic. This required that I move from having the option of personal, face to face interview to phone and online interviews. At this time, I adjusted the recruitment strategy to include recruitment through social media by posting the recruitment poster on Muslim social media groups on Facebook and WhatsApp groups with a request that nurses interested in participating are to contact me privately. Recruitment over social media provided me with the unique ability to reach nurses that may have been otherwise unavailable due to geographic location or because of the nature of shift work. The COVID-19 pandemic compounded these existing challenges, as nurses' workload has increased during the pandemic and as they continued to experience heightened physical and emotional stress in their daily practice settings (Ulrich et al., 2020). These added stressors may have negatively impacted recruitment, regardless of the adjustments I made. From this process, I gleaned the utility of a

wide and flexible recruitment strategy that enables recruitment of diverse participants to generate rich stories. Importantly, this adds to the trustworthiness of the study and its findings, as anti-Muslim racism is a systemic phenomenon that is not restricted to one region, health authority, or community.

When potential participants contacted me upon learning about the study, I assured them that all identifying information would be kept confidential and secure, as detailed in the consent form (Appendix D). I took the time to connect with potential participants and answer their questions on the processes involved in maintaining confidentiality. This also served another purpose: building rapport and trust with potential participants.

4.4 Data Generation

I began each interview by asking: *Can you tell me about your experiences as a Muslim nurse wearing hijab?* By asking participants to tell their stories, the researcher gives up control over the direction of the interview while collaborating with them to actively construct meaning. This open ended, broad, and non-suggestive interview question was based on the premise that most people like telling stories and with a little encouragement, they provide narrative accounts of their experiences during research interviews (Elliott, 2005; Riessman, 2008). As an open question, it promotes a relational and reflexive process (Riessman, 2008), while fostering a safe space for encouraging the nurses' agency. Such a question promotes trust building and is congruent with the premise of allowing for storytelling to begin at the starting point of the participant's choosing.

I actively listened during the interviews without interrupting to promote the emergent nature of storytelling and to gather rich data. I used probes to generate further explanations of the nurses' experiences, for example, *"Tell me more about that"; "What happened then?"*. I also used

a prepared list of questions as an interview guide (Appendix E), which I employed when interviewing nurses who needed more structure and encouragement to share their stories.

At the beginning of data generation, the nurses were given the option of participating in face-to-face interviews at a mutually agreed upon time or to be interviewed by the phone. This resulted in one in-person interview and two interviews over the phone. After changing the method of data generation to interviews via telephone, Skype, or Zoom due to the COVID-19 pandemic and to comply with the guidelines issued by the Chief Public Health Officer of Canada on social distancing and isolation, the remaining nurses opted for interviews over the phone. Telephone interviews are conducive to qualitative inquiry and are not necessarily inferior to in-person interviews (Farooq, 2015; Sullivan, 2012). They are effective approaches to data generation when travelling or time commitment can hinder participation, or when facing extraordinary circumstances, such as a pandemic.

All interviews averaged between 30 to 90 minutes. Nine of the interviews were audio-recorded. At the beginning of each interview, I obtained consent for audio-recording the interview. Interviews were audio-recorded as I needed to be attentive and actively listen during the interviews (Elliot, 2005; Riessman, 2008). I took handwritten notes for the first interview, which was the only face to face interview, as the nurse did not consent to being recorded. Each participant was assigned a number to ensure confidentiality. The voluntary nature of participation was underscored at the beginning, middle, and end of each interview. All paper documentation, including signed consent forms, written transcripts, as well as recorded interviews, were kept in my home office in a locked cabinet. All electronic data was stored in an encrypted and password protected computer folder, with the computer kept secured in a locked cabinet in my office.

Prior to recruitment, I received ethics approvals from the Human Research Ethics Boards of the University of British Columbia and the University of Victoria and Institutional Approvals from each of the health authorities that were included as recruitment sites.

4.5 Data Analysis

Interviews were transcribed verbatim, and I read each transcript closely multiple times with a focus on the content, or ‘what’ is being communicated rather than ‘how’ (Riessman, 2008). I followed Riessman’s (2008) case-centered analysis that focuses on preserving and appreciating the wholeness of each story, and not to “fracture the biographical account into thematic categories as...coding would do, but interprets it as a whole” (p. 57).

I began analyzing data and making interpretations as early as during the interviews. I attended to the holistic goal of data analysis of keeping the stories intact, preserving their entirety, focusing on the content, and understanding sections of the story within the context of the story as a whole (Elliot, 2005; Riessman, 2008). In case-centered analysis, the story is the case, and when the story is transcribed, it becomes the unit of analysis. Riessman maintains that case-centered approach to data analysis honors the participant’s individual agency and consciousness and emphasizes particularities and the contexts; it focuses on attention to detail within each narrative and the unfolding insights and complexities by paying attention to similarities, differences, and contradictions within and across cases (Riessman, 2008).

I began with multiple in-depth reads of each transcript, making sure to remain reflexive. I also read across the transcripts as a whole, while being intentional and attentive to commonalities, similarities, contradictions, and fragmentation within and across the cases. I then engaged in “‘compositing’ or the process of developing composite characters” to construct a

counter-narrative (Patton & Catching, 2009, p. 717). Compositing, Patton and Catching explain, is an integral procedure to protect the identities of participants in studies like this one, which otherwise can be easily identifiable if I followed a traditional approach to presenting the findings.

There is a limited number of nurses who wear a hijab and therefore, composite narratives offer an approach to illuminating the collective voices of the nurses without compromising my ethical commitment as a researcher to take all available steps to protect their identities and to eliminate or minimize any risks resulting from participation. Composite narratives are also helpful in presenting a coherent picture of the experiences of the group of the nurses while capturing their unique experiences.

4.5.1 Intersectionality as an Analytic Lens

As stated earlier, I employed intersectionality as an analytic tool to understand the complex experiences of Muslim nurses who wear a hijab and to unpack structural processes which shape their inclusivity and/or their marginalization. The focus of using an intersectional analysis is not on the intersections themselves, but on what those intersections reveal about power relations and unequal social relations (Dhamoon, 2011). Dhamoon explains that intersectional analysis allows for “understanding of processes and systems because it provides a multidimensional analysis of how power operates and its effects on different levels of political life” (p. 233). While ‘processes’ refers to the ways social locations are produced by the intersections of gender, race, religion, and so on, ‘systems’ encompasses “historically constituted structures of domination such as racism, colonialism, patriarchy, sexism, capitalism, and so on” (Dhamoon, 2011, p. 234). From this perspective, I was sensitive to how the nurses I interviewed

spoke of their multilevel experiences with racism within the current political and socioeconomic context while remaining attentive to the processes that shape their experiences.

Intersectionality is not only attentive to the intersections of gender, race and religion (as in this study), but is concerned with the ways these social categories are related to each other and are influenced or shaped by oppressive power structures (Black & Veenstra, 2011). Thus, an intersectional analysis strives to understand the nuanced and contextual experiences of people at the intersection of axes of difference (Hankivsky, 2014b), and allows for the examination of the interrelatedness of social inequities, processes of differentiation, and systems of domination at multiple levels (Anthias, 2012). Also, intersectional analysis guards against the categorization of research participants as “either intersectionally privileged and intersectionally oppressed”, allowing for the emergence of identities that simultaneously generate experiences of both discrimination and privilege (Hankivsky & Cormier, 2009, p. 9). For example, the COVID-19 pandemic affected nurses who wear a hijab in two main ways. Their hijab continued to be constructed as unsafe, especially when caring for patients who were either positive for the virus or being investigated for contact with an infected person. At the same time, some of the nurses were seen by their colleagues as ‘experts’ on head covering and consulted them on how to wear the head cover part of Personal Protection Equipment (PPE).

I applied intersectional analysis using questions that I adapted from Hankivsky and colleagues (2010), which capture the tenets and goals of intersectionality and align with the aims of this study. The questions are: 1) Who is being studied? Who is being compared to whom? Why? Here, I needed to situate myself, share my story as a Muslim nurse who wears a hijab and be reflexive about how my experience influenced data analysis; 2) What issues of domination and exploitation are being addressed by my research? Is the issue of power at the center of all

analyses? 3) How will human commonalities and differences be recognized without resorting to essentialism, false universalism, or obliviousness to historical and contemporary patterns of inequality? 4) How do I make sure that I am not seeing what I want to see in my research? And 5) Is the research framed within the current cultural, societal, and/or situational context?

Attending to these questions ensures that, throughout the analysis, I remain attentive to the interconnectedness between the experiences of the nurses while valuing their individuality, that I consider my own positionality and how it influences the process and the findings, as well as I examine power structures and power relations and their role in shaping the experiences of the nurses, and that I account for the contexts against which the nurses' experiences are constructed.

Intersectionality is an important analytical lens in exploring the gendered and racialized experiences of Canadian nurses who wear a hijab, as it provides a lens for examining interlocking systems of power. Riley (2011) argues that the gendered nature of anti-Muslim racism, in which Muslim women are discriminated against because of their clothing, reveals how sexism and racism interlock as systems of oppression that affect Muslim women in distinct ways compared to how sexism affects non-Muslim women and how anti-Muslim racism affects Muslim men. Therefore, such discrimination cannot be understood as simply the totality of the effects of anti-Muslim racism and sexism (Riley, 2011). Furthermore, a Muslim nurse who wears a hijab works in the particular contexts of the healthcare system, which are historically underpinned by structural racism and hierarchal structures. A Canadian Muslim nurse wearing a hijab does not face one-dimensional discrimination respectively as a woman, a Muslim, or a person of color. Rather, "her headscarf marks her as a terrorist, terrorist sympathizer, unassimilable foreigner, and an oppressed woman" (Aziz, 2012, p. 225), which significantly impacts her experience, as she faces multifaceted discrimination.

Since Canadian Muslim nurses who veil are also positioned within the contexts of their discipline and the healthcare system, intersectionality enables an in-depth exploration of their experiences that accounts for these contexts through the multilevel interrogation of power relations (Collins, 1993). The use of intersectionality ensures that, as a researcher, I attend equally to axes of difference when exploring the experiences of Canadian nurses who wear a hijab. Mens-Verhulst and Radtke (2006) argue that feminists take on a critical stance in their approach to conceptualizing axes of identity by placing them on a hierarchy ranging from important to most insignificant. Though some social identities might be more relevant in a specific social context, “a social researcher should never discard or ignore an axis a priori” (Black & Veenstra, 2011, p. 74). Intersectionality can illuminate which social axis of difference matter most to Muslim nurses who wear a hijab.

4.6 Trustworthiness

Trustworthiness refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2018). Researchers engaging in narrative inquiry must recognize and embrace the subjectivity inherent in the process, while allowing for the examination of how their subjectivity has influenced the research (Wang & Geale, 2015). There is consensus within the larger qualitative research community that the work by Lincoln and Guba’s (1985) on trustworthiness, which has been employed by researcher to evaluate their narrative studies, is the approach to assessing and ensuring the quality of qualitative research (Korstjens & Moser, 2017; Loh, 2013; Seale, 1999). Lincoln and Guba proposed trustworthiness over ‘validity’ to evaluate qualitative research, which includes the notions of credibility (parallel to internal validity), dependability (parallel to reliability), confirmability (parallels objectivity), and transferability (similar to external validity).

The first criterion for maintaining a trustworthy qualitative study is credibility, which is the confidence that can be placed on the research findings in relation to whether the findings represent correct and credible information that are drawn from the participants' accounts. A strategy that I used to establish credibility is theoretical triangulation by using multiple theoretical perspectives to guide the analysis of the data. Another approach I used to ensure credibility is keeping an 'audit trail', also a strategy to ensure dependability and confirmability of the findings, which is a documentation that captures what occurred throughout the research process to enable external checks and to demonstrate of reflexivity (Lietz & Zayas, 2010). I also engaged in reflexivity throughout the research process, as credibility is also ensured through reflexivity (Finlay, 1998; Jootun et al., 2009; McCabe & Holmes, 2009; Pillow, 2003), and is also central to the audit trail (Nowell et al., 2017). Thus, subjectivity is transformed from a problem into an opportunity where researchers no longer question the need for reflexivity, but ask how to be reflexive in research (Finlay, 2003). Reflexivity enhances the quality of research through the conscious engagement of researchers on examining how their positioning might assist or hamper the research process from beginning to end (Lietz et al., 2006). However, reflexivity is not only a measure or a reflection of credibility, but also a mechanism to inform the researcher, participants, and the research process (McCabe & Holmes, 2009), and is a tool to gain new depth in research and to know more about the self (England, 1994). It is through reflexivity that researchers acknowledge the change in themselves as a result of their research (Palaganas et al., 2017),

While dependability is the stability of findings over time and over the conditions of the study in which researchers ensure that the research process is logical, clearly documented, and can be edited (Polit & Beck, 2018), confirmability is concerned with the degree to which the

findings of the research study can be confirmed by establishing that the findings and interpretations are derived from the data (Korstjens & Moser, 2018). To ensure dependability and confirmability, I followed the strategy audit trail by ensuring transparency in describing the research steps throughout the study from the start of the research project to reporting findings. I kept a diary of decisions and inferences (decision trail) that I made during the research process to document how the research process was carried out and to foster my awareness of the impact of critical decisions that I took. For example, I kept a detailed record of changes to recruitment strategy and data generation, each action I took, and how these actions shaped the research process. When I used the guiding interview questions to probe the nurses during the interviewing process, I documented the reasons for such prompting, how proposing such questions might have shaped the interviews, and my intention behind asking any of the questions. I also documented the processes I used to collect and interpret data, explaining methodological decisions, describing how I interpreted the data, and providing alternative interpretations, if any existed.

Finally, researchers meet the criterion of transferability by providing a rich, detailed description of the contexts and of the participants (Korstjens & Moser, 2018). Ensuring the confidentiality of the nurses requires that data about their demographics, educational backgrounds, and the settings in which they practice are omitted from this study or from any future publications that are based on this study, mainly due to the smaller sample size of nurses and the risk that they can be easily identifiable if such information are shared. However, to contextualize the experiences of the nurses, I provided a detailed background describing the phenomena under study, the sociopolitical environment and the Canadian context in which nurses who veil practice within.

Chapter 5: Counter-Narrative: Muslim Nurses Speak Up

5.1 Introduction

The main purpose of this narrative inquiry is to examine the experiences of Canadian Muslim nurses who wear a hijab. The research questions that guided this inquiry were: 1) How do Muslim nurses' social locations that are produced at the intersections of gender-race-religion converge in understanding their experiences? 2) What are the power relations enacted within the discipline of Canadian nursing that produce and sustain social locations experienced by nurses who wear a hijab? 3) What are the ways these nurses resist their racialization and push against master-narratives that are constructed about them? Understanding the experiences of nurses who wear a hijab provides valuable insight into power structures and power relations operating within the discipline of nursing, with the goal of developing recommendations to inform and improve nursing research, practices, policy, and education. Further, documenting the experiences of nurses who wear a hijab fills a gap in knowledge, which is needed to inform the creation of a supportive environment to improve the enrollment of the nurses in nursing educational programs, their recruitment, and retention. In this chapter, I present the nurses' counter-narrative through 'composting' three composite narratives that convey the findings of the study followed by a discussion and further analysis of each composite narrative. The composite narratives were organized around key storylines from in-depth analysis of the interviews with ten Canadian nurses who wear a hijab. After listening to the nurses' stories, close and in-depth readings of each transcript and across the transcripts, and identifying key storylines, I constructed the composite narratives with the aim to convey the complexity of the nurses' experiences while preserving the confidentiality of their identities. To stay close to the nurses' experiences, the composite narratives contain verbatim data from the interviews.

These composite narratives reflect the use of strategic essentialism to present the collective experience of the nurses as a group with the goal of enacting transformational change within nursing and advancing social justice. The three composite narratives and the analytical discussions that follow constitute a counter-narrative that illuminates the voices of the nurses and works to shatter the foundation of the prevailing master-narratives about nurses who wear a hijab.

5.2 Composite Narratives

Collins (2009) suggests composite narratives speak collectively for the group instead of single individual experiences. Therefore, composite narratives can advance anti-racism in nursing through collective storytelling. This is akin to strategic essentialism to advance social justice (Spivak, 1988), in which essentializing the experiences of the nurses by grouping their experiences and presenting them in composite narratives is done strategically to communicate their collective voice and to push for transformational change within nursing. My intent behind using composite narratives to present the findings of the study is to foreground the strength of composite narratives in reflecting the ‘collective wisdom’ (Collins, 2009) of the nurses. As discussed earlier, composite narratives are an approach to present rich and contextual data while protecting the nurses’ identities, especially when there is a risk that they might be easily identifiable (Willis, 2019). Hence, I purposely constructed each composite narrative to contextualize the experiences of the nurses while weaving together verbatim extracts from the diverse interviews to illustrate key storylines from and across all the interviews.

The three composite narratives (Table 1) were constructed in the first person, and each narrative was told by a different nurse. I gave the narrative nurses the names Talat, Madiha, and

Yumna after the two Muslim women and young girl who were killed in London, Ontario at the time I was writing this dissertation. I chose to use their names to honor their lives, to shine a light on their story, and to chronicle their tragic death as a testimony to the dangers of Islamophobia and how it has continued to impact the lives of Canadian Muslims. It is also my hope that the loss of their lives fosters a space and willingness, as individuals, communities, and as a nation, to actively, begin to address and combat the roots of Islamophobia and to move towards creating spaces where we see one another as humans who share the goal and dream of living in a world free of racism, hate, and violence.

Table 1: Three Composite Narratives

Composite Narratives	Key Storylines
Composite Narrative #1 This is Who I Am: A Muslim Nurse With a Hijab and an Accent	Intersectional identities shaping the experiences of the nurses Having my nursing education and competence questioned Facing covert and overt racism
Composite Narrative #2 I Know What is at Play: Unveiling Operating Power Structures and Power Relations	Equating nurses who wear the hijab with terror and violence Constructing the hijab as unsafe and unclean Being excluded from leadership positions
Composite Narrative #3 Rewriting the Narrative: Navigating Power Structures and Power Relations	Asserting multiple meanings of the hijab Acting as ambassadors of Islam Reclaiming control

In the first composite narrative, Talat positions herself as a nurse who wears a hijab with multiple intersectional identities that have shaped her nursing education and everyday practice. In the second narrative, Madiha, who was born, raised, and educated in Canada, reflects on the power dynamics and structures within nursing that have shaped her experiences with anti-Muslim racism and have continued to position her as the racialized ‘Other’. In the third composite narrative, Yumna conveys her decade of experience as a nurse working across Canada in different nursing positions. In this final narrative, Yumna illustrates the ways in which she has adopted strategies to claim control over the narrative about her as a Muslim nurse who wear a hijab and to resist and mitigate the negative impacts of her racialization within nursing.

5.2.1 First Composite Narrative: This is Who I am: A Muslim Nurse With a Hijab and an Accent

My name is Talat. I am a Muslim nurse and I wear the hijab, and I speak with an accent (or so people tell me). Unfortunately, throughout my nursing career, I have had harmful experiences because of the way I look and how I speak. I may not feel different, but I am different. I do not see myself as different until it is pointed out; and it is pointed out in subtle and openly hostile ways. When this happens, I stand back and think ‘oh yeah, I’m the nurse with the thing on my head.

Frequently, I am reminded that I am different, and that I must remember that I ought to conduct myself differently. Every so often, when I walk into these patients’ rooms, when I introduce myself, I am reminded of my differences by the many questions I am asked, which feel more like I am under scrutiny, like hurdles I need to overcome. *How long have you worked here? Where did you go to school? Are you forced to wear that? Oh, what is your accent?*

This is something that my colleagues and I do not have in common. They are not asked how long they have been nursing and where they got their nursing degrees and what accents they have. No

one is asking my colleague from Newfoundland with a very heavy accent where he is from. Usually, when I am asked where I received my nursing education. I cannot shake the undertone of this question which is doubting my competency as a nurse. It has become tiresome to expect these questions and to be on guard, always be prepared to answer as openly as possible.

At work in the hospital, I experience subtle racism regularly. While others may not see it that way, it's obvious to me through people's body language and in their mannerisms; like when I began working on a unit and when I would walk into the nurses' station, the nurses would look the other way. And quite honestly, I'd rather be told directly to 'take it off' rather than having a patient, a colleague, or a manager look at me strangely. Along with this subtle racism, I also experience blatant racism. I have been called derogatory racial names and have been singled out by patients to leave the room. I have had my competence and education doubted and questioned. It makes me upset; it makes me feel sorrowful that after all that I do, I am not trusted.

My experiences in nursing school in British Columbia were deeply shaped by there being no other racialized students or educators in my program. It was frustrating when instructors and students would question my ability to comprehend the material or when they seemed to doubt that I was capable of excelling when I received good marks. One instructor wanted to fail me because she thought I could not understand her. Each semester, she seemed to pick the most vulnerable among the students, and that term she chose me. She saw my vulnerability in my hijab and accent. When I would bring my knowledge from previous learning to class discussions, she resented my contributions. I think it was easier for her to choose to not hear me. That instructor and others have an image of what a good nurse is, a mold that they want their students to fit into, but that I could never resemble or sound like.

Unfortunately, I experienced similar attitudes from nursing students. Most students did not want me to take part in their group work and projects. They did not think I was good enough. They saw my accent as a weakness that would impact them negatively. It was easier to label me, just like nurses putting the 'purple dot' on a patient's chart; a system that is used in healthcare settings to identify patients known for violent behaviour. Outside of school, I was not their 'fun friend'; I was not invited to their social events; I did not go out to drink or was included in their socializing group.

In the hospital, instructors and nurses were afraid of the ‘unknown’. They did not know my background, did not know me as a person, did not know how to help me to learn, or how I could offer help or be of value. Patients were mostly the same, they did not want a Muslim nurse, believing that a Muslim nurse with hijab is not going to be as good in taking care of them as other nurses. Interestingly, I think it’s about trust. As a practicing nurse wearing the hijab, my differences seem to spark a lack of trust. When I first enter a patient’s room and introduce myself, their first impression is that I am not going to provide them with adequate care because I am seen to be from a different place, because I am different. Their assumption is that I am not qualified; that I am under-educated. I can feel it right away when I introduce myself to a patient or a family member, I can sense their skepticism of me. They don’t trust me.

I also do not belong to what colleagues call their work family. I do not and have never felt like that. When I think about why this is the case, I remember that I do not hang out with my colleagues. My exclusion is made all the worse when I am blamed for not attending social events, when really, the nature of these social events negates my attendance. After a while, I was no longer invited.

Analytical Discussion

The storylines in this composite narrative illuminate the experiences of nurses who wear a hijab by locating them within their intersectional identities and by critically examining the perception of their (in)capabilities by questioning their nursing education and competence as an intersectional marker. The nurses’ experiences with both covert and overt racism were highlighted to amplify their voices and to uncover the multiple ways in which Islamophobia operates within the context of Canadian nursing, which remains largely ignored.

Primarily, the nurses’ stories uncovered the role that their intersectional identities play in shaping their experiences. Along with the hypervisibility of the hijab, speaking with a non-native accent and the perception of the nurses’ (in)capabilities were closely related axes of difference that shaped their experiences with Islamophobia. While speaking with a non-native

accent functioned as an inclusion/exclusion gatekeeper, the perception of their (in)capabilities through the frequent interrogation of their education and competency was highlighted as another axis of difference, as the education of nurses who wear a hijab was devalued, distrusted, and thus they were construed as incapable, undereducated and incompetent. This also underscored the intersection of class, as discussed below, and its role in the division of labor within nursing, as another maker of difference. Further, the stories of the nurses clearly captured their daily experiences with both covert and overt forms of racism.

Intersectional Identities Shaping the Experience of the Nurses

Though the hijab is an explicit visual representation that renders its wearers ‘Muslim’, the experiences of Muslim nurses who wear it were also shaped by their racialized and gendered identities, by their non-native accent, and by the perception of their (in)capabilities as nurses. Speaking with a non-native accent emerged as an important identity marker that contributed to shaping the nurses’ experiences with anti-Muslim racism, in that it rendered them outsiders and unqualified in the eyes of their patients, colleagues, and managers. The perception of the nurses’ (in)capabilities emerged as another axis of difference, wherein their nursing education and their competence were frequently questioned. The importance of this perception as an axis of difference is apparent in that it surfaced as a main storyline across the nurses’ stories.

The racialization of Canadian nurses who wear a hijab was enacted through their religious traits and attributes and based on phenotypical characteristics such as their non-native accent. Though the intersectional identities of nurses who wear a hijab were not limited to their religious affiliations, the hijab remained a central theme and its role in shaping her experiences was undeniable. Hampton and Hartman (2019) contend that “whether or not a Muslim woman

identifies and/or is racially coded as Black, Brown, White, or otherwise, the hijab itself functions as a racial and racializing signifier” (p. 3). Hence, the hijab played a central role the ways in which Muslim nurses were perceived by others. It also shaped their experiences with anti-Muslim racism within the discipline of nursing, which is consistent with studies that demonstrate how Muslim women who wear the hijab are more likely to face discrimination in the workplace (Aziz, 2012; Koura, 2018; Meshal, 2003; Tariq & Syed, 2017).

The hijab was fundamental in the construction of the nurse who wears it as a stranger figure who does not belong; an image that provokes fear and hostility (Zempi & Chakraborti, 2014). Their hijab acted as an emblem of their Otherness, reinforcing the binary of ‘us’ and ‘them’ and functioned as a “racializing agent” (Selod, 2018, p. 79). The nurses’ experiences underscored Zempi and Chakraborti’s (2014) assertion “that the veil has simultaneously become a ‘visual identifier’ of Islam and an embodiment of what is in itself stereotypically Islamophobic: namely, the veil as a symbol of Muslim ‘[O]therness’” (p. 32).

Muslim women who wear a hijab face the burden of negative and stereotypical representations of them and of their religion within the circulating political and social discourses (Alimahomed-Wilson, 2017). A common stereotypical assumption about women who veil is that they are forced to wear it, and therefore, they are oppressed and agency-less (Selod, 2018). Questioning the nurses about being coerced to wear the hijab demonstrated how the colonial Orientalist assumptions about the veil as inherently oppressive and a symbol of patriarchal rule have infiltrated the discourse on the hijab within the nursing discipline. To the contrary, most women who veil adopt the practice out of choice (Furseth, 2011; Williams & Vashi, 2007). Those who question the free will behind the practice of veiling fail to recognize that within a democratic society, such as Canada, it is a women’s fundamental right to dress the way they

choose. The contextual complexity of the hijab as a practice and its varied and diverse meanings require that I also acknowledge that it has been forced upon women throughout history and continues to be an obligatory practice in some Muslim countries where women are pressured to wear it by their families, communities, and by the state (Bullock & Jafri, 2000; Cole & Ahmadi, 2003). However, the essentialist, reductionist portrayal of nurses who wear a hijab as agency-less and oppressed ignores the diversity among them and the multiple forms and meanings of the veil and carves a place for them where they need to constantly explain themselves and justify their choices.

Further, speaking with a non-native accent emerged as an important axis of difference across the stories. Matsuda (1991) explains that accents are not about choice of words but are about pronunciation. Matsuda continues to put forward the argument that accents are windows into who we are, the identities we hold, and the lives we live. In this vein, we are inseparable from the accents we speak with (Matsuda, 1991). Accents function as signifiers and identity markers, which explains accent-based discrimination. As in other forms of discrimination, power is at the heart of accent discrimination between dominant and racialized groups (Creese & Kambere, 2003; Guo, 2009; Matsuda, 1991). Accent discrimination is enacted when those in positions of power are perceived as speaking accent free English or speaking with superior accents. Accent discrimination also functions through assigning negative stereotypes to those who speak with non-native accents by constructing them as less competent, intelligent, and uneducated or undereducated (Creese & Kambere, 2003; Lippi-Green, 1997; Munro, 2003; Pantos & Perkins 2013).

Thus far, the experiences of nurses who wear a hijab demonstrated the function of accents as a border, a gatekeeper that regulated their inclusion/exclusion (Kayaalp, 2016). The

contrast between the experience of being questioned about their non-native accents while their Canadian colleagues who speak with native accents were spared from such questioning revealed the function of accents as a border regulating what signifies the norm, who belongs and who does not, and who is considered Canadian and who is flagged as foreign. Fundamentally, this is congruent with the construction of the image of the Orient as an outsider, a foreigner, and as backward and uncivilized (Said, 1978).

Having My Nursing Education and Competence Questioned

Regarding the nurses who wear a hijab as incapable through the devaluation of their education and care competence emerged as another salient intersectional marker of difference. Caring does not exist in a vacuum and the notion of care competence, as articulated by Raghuram (2019), is hierarchical wherein the competencies of some people are valued more than those of others, as ‘competence’ “circulates in a world where skills are geopolitically coded and ascribed differentially based on color” (p. 620). Raghuram argues that race has been central to the division of caring labor in settler colonial states as colonialism has created a racialized division of care, producing and reframing existing racial divisions and differences using the language of care (e.g., caring for the freedom and agency of Muslim women to justify wars and advancing the colonial project). The stratification of racially marked competence is underpinned by the historical and political context that continues to shape the value placed on care (Raghuram, 2019). Therefore, when care is provided by upper or middle-class, ethnically European women, it is casted as pure and as embodying their competence, attentiveness, and caring.

The unfounded assumption that nurses who wear a hijab are simply incapable through devaluing of their education and competence unmask the role of class as a socially constructed

category in producing and maintaining discriminatory and exclusionary practices. Class analysis, as with gender analysis, is central to the experiences of the nurses, as class-based racism is rooted in the history of nursing where “race, gender and class together created nursing as race- and class-stratified ‘women's work’ where the division of work is divided across the racial lines” (Scherzer, 2003, p. 23). Historically, racialized nurses have been excluded from secure and better paid and desirable jobs through systemic practices within the labor market and in other related institutions, such as the educational and the immigration systems (Gupta, 1996). For example, the experiences of Black nurses in Ontario exposed personal and institutional practices that effectively forced them into low-status jobs that were viewed as unfit for White nurses, which in turn pointed to the ongoing discrimination within nursing based on gender, race, and class (Modibo, 2004). In this study, the historical context of nursing in relation to racialized nurses persisted in which the nursing education and competence of well-educated Muslim nurses who wear a hijab were underrecognized. They were seen through the historical lens of the division of labor in nursing where their construction as under-educated and under-skilled overpowered their licensure as registered nurses.

Assuming the (in)capability of the nurses by undervaluing and questioning the education and competence is an outcome of equating the hijab with ignorance wherein Muslim women who wear it are not only perceived as lacking agency but are also presumed to have lower levels of education (Rahmath et al., 2016). Interrogating and questioning the nurses’ education and competence point to how their capabilities were doubted by patients, their families, and other nurses, and therefore, cannot be trusted. These assumptions have permeated their workplace and have contributed to negative and enduring experiences of exclusion. Similarly, racialized nurses in previous studies reported that their competence and skills were often devalued, and their status

as qualified nurses discounted, leading to their feeling of lack of trust in them by their patients, colleagues, and managers (Allan et al., 2009; Mapedzahama et al., 2012; Whitfield-Harris et al., 2017). The capability of nurses to provide care that is safe and to demonstrate individual and professional competencies in order to gain the trust of their patients, colleagues, and the larger society are among the core ethical values of nursing (Shahriari et al., 2013). Trust is an important aspect of nursing that is closely related to the image of nurses (which is influenced by the color and the style of their uniform), shaping the perceptions of them, which in turn dictates feelings of trust and satisfaction with nursing care (Albert et al., 2008). Casting nurses who wear a hijab as incapable by constructing them as under-educated and incompetent interrupts and may terminate the trust in them as competent care provider. Hence, devaluing their education and doubting their competence strip the nurses from the basic and important values of their discipline and create a negative image of them in which the image of the ‘White Christian good nurse’ is reflected against. Thus, undervaluing the education and competence of nurses who wear a hijab fits with the argument made by Al-Saji (2010) that Western representations of veiled Muslim women are not about Muslim women themselves, but rather serve as a negative mirror in which gender within the West is positively constructed against. Al-Saji puts forward the argument that though “what is represented as inevitably oppressive is the Muslim veil in general, it is representations of the veil themselves that demand and enforce the exclusion of Muslim women” (p. 877).

Facing Covert and Overt Racism

Racism often manifests in subtle forms, rather than in direct and blatant actions and words, through attitudes and mannerisms which “can be revealed through heightened suspicion or distrust of a people based on perceived racial difference” (Phillips-Beck et al., 2020, p. 3). Covert racism is harder to call out and to challenge than that of blatant racism, as it thrives on the

uncertainty of the motives behind the treatment of racialized people. At its core, covert racism thrives in Canada and in Canadian nursing as it hides behind the social liberal values and the professional caring values of the discipline (Hilario et al., 2018; Turritin et al., 2002). Consistent with the existing literature on the experiences of veiled women in which the hijab is a salient factor in their experiences of discrimination (Zine, 2006), the nurses spoke of their experiences with both covert and overt racism. They underscored that the most insidious interactions they had with patients and other nurses were moments of subtle racism, coded in mannerisms, language, and tone of voice. Covert racism also takes the form of social isolation such as being excluded from participating in social events. This exclusion is often invisible and represents a form of discrimination that is settled and not verbally communicated (Ferris et al., 2008). The experiences of the nurses with both covert and overt racism were inseparable from the intersections of their gendered and racialized identities and the social locations they occupy.

The experiences of nurses who wear a hijab were also consistent with the documented experiences of Black nurses within the literature, which hold testimonies of racially based treatments at the interpersonal, organizational, and systemic levels (Barbee, 1993; Gupta, 1996, 2008; Truitt & Snyder, 2020). In a recent key message on anti-Black racism, the Canadian Nurses Association (CNA, 2020) acknowledges that the violent history of colonization and slavery in Canada have laid the grounds for anti-Black racism. CNA also recognizes that anti-Black racism is a part of the history of Canadian nursing that has continued to reproduce the conditions that keep Black nurses from attaining leadership and advanced practice positions. Importantly, nursing as a microcosm of the larger society reflects power relations that obscure racism through its maintenance of Whiteness, including 'acting White' as a value that eases the acceptance of students, nurses, and faculty members within the discipline (Puzan, 2003). Further,

in an open letter to the CNA, Prendergast, Abumbi, and Beausoleil (2020) emphasize the urgency of addressing racism within the current contexts of Black Lives Matters protests and the killing of George Floyd, the disproportional death of Black people due to the COVID-19 pandemic, and the plight of racialized groups in their continuing struggle with racism.

Prendergast and colleagues also reference, as Black nurse educators, their struggle with racism which they experienced personally and as a community.

The nurses' experiences with racism, in my study, were not limited to the workplace, but included their time within the academy. As nursing students, the nurses were perceived by some faculty members, some of their peers, and by some nurses within the clinical practice settings as incapable of succeeding in their studies and as outsiders who did not belong. Nursing and nursing education operate within the academy, the healthcare system, and largely within Canada as a settler colonial power where racial beliefs and practices remain the foundations of these systems (Puzan, 2003). Within these contexts, most nurses are White, and nursing education and the nursing discipline are stratified along racial lines where White nurses are positioned at the leadership, managerial levels and hold the largest bulk of academic assignments (Gustafson, 2007; Van Herk et al., 2011). Hence, the educational environment within nursing has continued to be unsupportive, unwelcoming and even hostile to racialized students and faculty (Hassouneh, 2006; 2013).

As seen in Talat's narrative, the racist actions by other nursing students towards students who wear a hijab insinuate the power and privilege the students hold. Bell (2021) provides a compelling explanation of how nursing students, who are mostly White and in their early twenties, have bought into the narrative of color-blindness within neoliberal multiculturalism that dilutes the presence of racism under the claims of equal and respectful treatments of all. Bell

explains that the young age of nursing students has not precluded them from adopting these ideals. She speaks to the “ubiquitous nature of both personal and professional socialization and the persistence of these race-erasing ideals in nursing” (p. 3), and how they have continued to reproduce the normative Eurocentric ways and practices and to obliterate racism and oppression.

The prevalence of racism within nursing education has its roots in what is included and what is excluded from the nursing curricula. Bell (2021) argues that a main flaw in nursing education is the implicit and, at times, direct presentation of race as biological instead of a social construct, which reproduces racism that hides behind so-called scientific explanations or rationalization and reinforces assumptions and circulating stereotypes that are attached to different races. Bell explicates that as long as the “beliefs about biological differences between groups of people along purported racial lines persist in our institutions”, very little progress towards social justice is to be expected, as this educational environment impacts not only the nurse-patient relationships but also the relationships between students, educators and among students and educator (p. 4).

On the other hand, systemic racism is frequently ignored or glanced over in nursing curricula and nursing educational programs fail to prepare nursing students to work with racialized patients and staff and to effectively address racism and oppression (Blanchet Garneau et al., 2018; Prendergast et al., 2020). Indeed, culturalism obscures race and results in equating race/ethnicity with culture rather than looking at race as a social construct that is rooted in colonialism (Bell, 2020). Because culture is often conflated with race, there is a reliance on teaching cultural awareness and cultural competence, resulting in ignoring the social construction of axes of difference that maintain and reproduce structures of power and privilege within the nursing discipline (Blanchet Garneau et al., 2018).

Racism within nursing education is also evident in the lack of diversity amongst faculty and in the negative experiences of racialized faculty. Institutional racism is a main obstacle that stands in the way of attaining equal representation of racialized nurses within the academy. Tuitt and colleagues (2009) confirm that the rate of racialized faculty in nursing educational institutions is often disproportionately low, and when racialized nurses are hired into teaching positions, they are usually marginalized, slotted within stereotypical assumptions about them, and usually experience covert and overt racism. Furthermore, racialized faculty members often feel that they are token hires and experience loneliness and isolation (Beard & Volcy, 2013). Hassouneh (2013) directly links the experiences of racialized nursing students and faculty with racism to the glaring absence of diverse faculty within nursing programs.

Indeed, the hijab and what it represents within nursing require a great amount of energy and time expended by nurses who wear a hijab to push against its negative representations, to demonstrate their competence, and to push against the place of deficit that is carved for them. Though an examination of the extent of the emotional and mental distress that burdens these nurses is outside the scope of this study, it is evident that the nurses struggled with the demands that they constantly demonstrate that they are not what they were constructed to be. The nurses' account about facing both covert and overt racism "suggests that until there is a shift in attention in regard to this matter, it will remain poorly addressed in health care ethics and related policy and practice processes" (Johnstone & Kanitsaki, 2010, p. 492). Indeed, as asserted by Johnstone and Kanitsaki, racism is an ethical issue and its moral implications for healthcare providers are widely neglected. It is a moral wrong that violates the universal and fundamental ethical principle of 'do no harm' (Johnstone & Kanitsaki, 2010; Raghuram, 2019), and goes against the social justice mandate of nursing (Beard et al., 2020). Further, the moral duty of care, which is at

the heart of care ethics, is more than the passive notion of ‘do no harm’. Enacting an ethics of care that is embedded in the principles of sensitivity to the contexts, responsiveness, and attentiveness requires moving beyond ensuring that no harm is done “to calling for active interference when harm is witnessed” (Zaidi et al., 2021, p. 2). It commands active engagement and taking on actions that improve the lives of those who are excluded and or marginalized. In this vein, nursing needs to honor the principles of care ethics to recognize individualized and diverse needs, develop sensitive and flexible policies to meet them, and create an environment that fosters empathy and trust (Schmid, 2019).

5.2.2 Second Composite Narrative: I Know What is at Play: Unveiling Operating Power Structures and Power Relations

My name is Madiha. I was born in Canada, raised in Canada, and educated as a nurse in Canada. But, because I wear the hijab, patients, their family members, and other nurses frequently question where I am from and how long I have lived in Canada. In response, I often explain that I am Canadian, born and raised in Canada, and that I studied in Canada. I am often surprised that I am not always bothered by it; I think maybe it makes me reflect on why this question is being asked.

I remember talking to a colleague and I parroted these questions, letting her know that these are the types of inquiries I receive every day of my work. She was mortified. For me, these questions were typical and routine, I have been receiving them since nursing school. Apparently, she’d never been asked questions like these. This was a real turning point for me. In talking to her, I realized how atypical these types of questions are and how the premise of these questions, to highlight and interrogate my Otherness, is not okay. Of course, I knew that there was something insidious behind these questions, but I didn’t grasp the pervasiveness of them in my nursing career against their stark absence from those of my colleagues. Looking back, I can only explain that it is what it is. Though this realization makes me feel all the more different from my colleagues, all the more separated from the people I have worked with for years, it also opened

me up to how being questioned like this is normal to me. What was normal to me was absolutely not normal for my nursing colleagues.

Being a Black nurse, I have many experiences of being called racial slurs, including the N-word. The first time, I was shocked and surprised, but chalked it up to the ignorance of the patient. I remember a colleague of mine at the time started crying. She broke down and said, "I'm so sorry that this happened to you". Other devastating moments were the times I was called a terrorist. The first time it happened was when I went into this patient's room and her son was there. Upon seeing me, seeing my hijab, he said "You do bad things. You're a bad person. You people are bad". He kept repeating these hurtful words and I could not help but cry. Another patient refused to have me as his nurse. When I asked him why, his exact answer was that he felt threatened by me because I wear the hijab, that the way I look made him think of all the violence that is happening in the Middle East. Other times, patients will take one look at me and say they do not want me to care for them. "You're one of them," one patient said. Just recently, a patient called me a terrorist.

Sadly, in the face of these experiences, I rarely feel supported. The next shift after that most recent experience, I was again assigned to this same patient, despite the harm and trauma I had already undergone. I should not have been put back in this unsafe situation. It did him no justice and it did not do me any justice to look after him.

My career goal is to work in a leadership capacity, but I have found no success, though not for a lack of effort. A while ago, I applied for a leadership position and did not even receive an interview, despite me being the only candidate with the required educational background. This was made worse by the lack of transparency on how this decision was made. It was an internal hire, and I was not even aware that I was not a candidate for an interview. I found out on a Friday evening at the end of my shift while juggling six patients. My manager came up to my bedside and said something about not being shortlisted for an interview; she said it so quickly that I did not catch it at first. Indisputably, this was not an appropriate time to inform me of this. Between the busyness of my patients and it being a Friday evening, I had no opportunity to follow up with my manager or to have a conversation before the interviews were conducted on

Monday. Just the day before, I felt optimistic that I would receive an invitation to interview. Evidently, I was not even on her radar as far as a potential candidate. I felt hurt and unseen. Just after she came and told me, I went to her office, but she was no longer there. She informed me on her way out of the office.

Recently, my colleague has been trying to convince me to apply for that same position as it was recently reposted. When I told her about my previous experience, she said a main consideration among hiring managers is whether a candidate is a good fit with the other leadership members. Well, I do not fit in anywhere. Despite doing my work the best that I can, I do not fit, and I do not belong. I stand out. There is them and there is me, which is made clear when I am being considered for a job position. Forget the qualifications, am I the right fit? Will I be someone that they want to chat to about family and pets and their social lives? Well, probably not. We do not lead the same lives.

Another structural challenge I have faced was the implications of the practices within infection prevention and control. During my nursing education, I had instructors who were concerned about my hijab, saying that it imposes a safety risk in that a patient could use it to strangle me. Instructors also questioned the color of my hijab and its cleanliness. This has continued into my career as a registered nurse. An infection control nurse once approached me and questioned my hijab, calling it unclean and unhealthy to patients. I challenged her, asking her, “what is the difference between me washing and changing my hijab before each shift to another nurse who goes home and washes her hair?” Regardless, these concerns have prevented me from working in certain specialties, such as working in the Operating Room (OR).

I remember when I was hired into a new job, part of the orientation was a tour of the OR. I was excited to begin working and was considering a future career in the OR. The OR nurse immediately said to me, “You can’t go in like that, you can’t go in with that thing on your head and with your sleeves not rolled up. Other people don’t do that, other people just take it off before walking into the OR. You cannot do that.” This being my first day on the job coupled by the public embarrassment of this confrontation left me stressed and certain that I was not suitable to work in the OR.

Very recently, during the COVID-19 pandemic, there were concerns about whether I could wear my hijab into the rooms of potentially infected patients or if I had to use an extra hair cover. There were concerns about whether my head scarf invalidated my ability to safely provide care. The rationale was that nurses must cover their hair with a hair cover or a hat and remove it when exiting the room. Therefore, if I were to go into patient rooms, then I would need to take my hijab off upon exiting the room. Alternatively, I could wear a hair bonnet, which is a hair cap over my hijab. But now with the pandemic and the practice of healthcare providers covering their hair and keeping that cover on throughout their shift, it has been kind of nice, because I am sort of an expert as I have been covering my hair for a long time. I am asked by other nurses about what I recommend, how I put my hair up. I feel like it has started conversations and I feel like my colleagues have been thankful for my willingness to answer their questions. It has helped to get rid of the stigma that surrounds Muslim women. Specifically, that our men force us to wear the hijab.

Analytical Discussion

A key finding of this study is the processes in which racialization within nursing functions to perpetuate and maintain White privilege while oppressing nurses who wear a hijab. As Madiha's narrative conveys, racialization as a process is fluid and context dependent. In liberal democratic societies such as Canada, the liberal democratic values of individual freedoms and egalitarianism make the processes of racialization more ambiguous and often render discussions on discrimination and Othering irrelevant and unfounded (Henry & Tator, 2009). Specific to the context of nursing, the values of professionalism, caring, and empathy mask the unequal power structures and power relations operating within the socially constructed differences about people, including racialized nurses. I borrow the argument made by Tang and Browne (2008) that "the personal cannot be separated from the historical" (p. 124) to contend that the actions of patients, family members, and non-racialized nurses,

namely White nurses and managers, cannot be separated from their historical location as members of a privileged group that benefit from the systemic and historically embedded structures of power that sustain their privilege. Indeed, the actions of non-racialized patients, family members, and nurses may not be intended to cause harm or oppression. However, operating within a system of unequal powers and race relations that is left unquestioned will inevitably marginalize and oppress racialized nurses.

The storylines in this composite narrative capture power structures and power relations embedded within racialization processes operating within Canadian nursing and experienced by nurses who wear a hijab through equating the hijab with terror and violence, constructing the hijab as unsafe and unclean, and by the systemic exclusion of nurses who wear a hijab from leadership positions and specialized areas of nursing. The experiences of the nurses were a testimony to Said (1978) and Spivak's (1988) arguments about the Orientalist/subaltern where these scholars assert that the colonial images of the Orient/subaltern are distorted and homogenized and assigned negative meanings within Western discourse; a discourse that permeates into nursing, endorsing the racist treatment of nurses who, by wearing a hijab, are identifiable as Muslims.

Equating Nurses Who Wear the Hijab with Terror and Violence

The visibility of the hijab as a religious practice is challenging in that it turns the gaze on the nurses who wear it; it makes them immediately recognizable as Muslim and thus, their religious identity is always present throughout their interactions and experiences as nurses. The hijab shapes first impressions, evokes assumptions, generates questions, and engenders scrutiny; it is often associated with terror and violence, leading to equating nurses who wear a hijab with

terrorism. This false equivalency is a racialization process that reveals the paradoxes embedded within the simultaneous construction of the hijab as a symbol of oppression and as a threat where women who veil are seen as subjugated, who must be freed and simultaneously, must be feared. In this sense, the construction of the hijab only serves to maintain the position of nurses like Madiha, where depending on the contexts, nurses who wear a hijab are either seen as oppressed or as a threat. All the nurses in this study shared stories of patients and their family members equating the hijab with terror and violence. The racial categorization of nurses who wear the hijab as threatening terrorists illuminated their experiences with gendered Islamophobia as a form of racialized discrimination that is leveled against Muslim women (Zine, 2006). This gendered Islamophobia, though clearly evident within post 9/11 era, is rooted in Orientalist colonial representations that cast Muslim women as stranger figures.

Indeed, “[t]he hijab itself is neither liberating nor oppressive; the power relations invested in it are situational and contextual” (Frank, 2000, p. 918). However, the hijab has been riddled with sentiments of violence and terror that shaped the experiences of nurses like Madiha and dictated their interactions with coworkers, patients, and nursing faculty. Importantly, the experiences of nurses in this study were not isolated from the larger Canadian context; they were a manifestation of how the hijab has been constructed in public and political discourses that permeated the discipline of nursing. Moreover, the experiences of nurses who wear the hijab were situated within the history of Canada as a subjugating and colonial power. In this way, the experiences of these nurses indicated a larger systemic issue of oppressing racialized people and communities of which many are immigrants, refugees, or newcomers to Canada and who continue to experience Othering through the legal, political, and social processes (Tuyisenge & Goldenberg, 2021).

Furthermore, frequently questioning the country of origin of nurses who wear the hijab perpetuated and maintained White privilege while further oppressing the nurses. When a nurse who wears a hijab is frequently asked “*where are you from?*”, her citizenship is doubted and her image as a foreigner and an outsider is reinforced. Embedded within this question were often stereotypical assumptions about the nurses that produce and reproduce discrimination and Othering. It communicated to the nurses that they do not belong to the citizenry and were undeserving of being Canadian. Indeed, the privilege White nurses hold in taking their Canadian citizenship for granted constitutes a facet in which private citizens participate in the racialization of Muslims. Selod (2018) asserts that private citizens participate in the racialization of Muslims when they watch and interrogate them in both public and private spaces. Selod further explains that one of the ways in which private citizens surveil Muslims is by questioning their nationality. As in Madiha’s story, the hijab was constructed as foreign and the bodies of nurses who wear it were placed under the gaze and scrutiny of private citizens, namely other nurses, patients, and their families.

The stories of the nurses in this study also shined a light on the experiences of Black nurses who veil with blatant and intense racism, like being called the N-word. Their experiences are uniquely shaped by the history of anti-Black racism and slavery in Canada. When making this assertion, I do not imply the absence of gender, religion, non-native accent, and the devaluing of nursing education in shaping these experiences but to emphasize that racialization functions differently based on the contexts (Hampton & Hartman, 2019). However, though racialization processes are fluid and involve changing mechanisms and evolving practices that attach racial meanings to people (Selod, 2018), they all are reductive in that “the simultaneous

processes of racialization often exclude the complexity of multiple, relational identities” (Hampton & Hartman, 2019, p. 6).

In the face of such discrimination, reorienting nursing to intersectionally informed care ethics poses the potential of shifting the discourse within nursing to one that appreciates culturally and religiously different practices (Schmid, 2019). Importantly, the discourse on the veil and nurses who wear it can once again be shifted to be characterized by caring and respectful construction. For this to happen, as suggested by Schmid (2019), politicians, educational institutions, and the media could reintroduce a discourse where care practices are rooted in empathy, trust, and respect. I also contend that to shift the discourse, the experiences of nurses who wear a hijab need to be illuminated and their counter-narrative are to be shared and amplified, which is a main goal of this study.

Constructing the Hijab as Unclean and Unsafe

At the organizational level, the narrative on the hijab as foreign and unsafe is echoed in the stories of the nurses in relation to their experiences with infection control and prevention (ICP) practices during their nursing education and at their practice settings. In nursing schools, the nurses in this study shared their experiences of being singled out and told by faculty and nurses in their clinical practice settings that their hijab was unclean and posed a safety risk to the patients and to the nurses themselves. The hijab was perceived as a risk to the nurses’ safety in that it posed a possibility of strangulation by patients and as a mode of transporting infectious agents between patients and to staff. Based on this construction, the nurses were singled out and implicitly accused of endangering the safety and wellbeing of patients, which is antithetical to what a good nurse represents. Hence, an image of the unsafe and unclean

nurse who wears a hijab was constructed to stand in contrast to the image of the White good Christian nurse'. The negative framing of the hijab by nursing faculty and by other nurses meant that nurses who wear a hijab had to start from a place of imaginary deficit to prove that they were safe nurses compared to their White counterparts.

ICP practices contain processes of racialization that are covert and subtle. The hijab within ICP practices has been constructed as a foreign item of clothing that does not align with what is normalized as a nurse's dress or uniform, which is derived from a master-narrative that deems it foreign as a practice. Malik and colleagues (2019) explored the experiences of female Muslim healthcare providers wearing a headscarf in the OR and investigated the mandatory dress code of having 'arms bare below the elbows' within the United Kingdom. Their findings delineated multiple challenges for healthcare providers wearing a headscarf in the OR (51.5%), some felt embarrassed (23.4%), anxious (37.1%), and bullied (36.5%). These findings have implications on the opportunities available for nurses who wear a hijab within advanced practice as specialized nurses by the virtue of their religious dress. Hence, ICP practices continue to operate at the organizational level as a barrier preventing nurses who wear a hijab from accessing some specialized nursing opportunities and disadvantage them compared to nurses who do not wear religious headdress to practice. Indeed, the shared experiences of nurses who wear a hijab in relation to ICP practices also underscored how they were often singled out based on their unconformity to the normalized dress codes within nursing. Importantly, singling out nurses who wear a hijab in this way further contributed to their Othering and exclusion.

As I mentioned earlier, the interviewing process for this study continued over the first months of the COVID-19 pandemic, which has already shone a light on the disproportionate

impact of the pandemic on racialized people and communities and on the spread of racism towards racialize people in Canada (Al-Qazzaz, 2020; Lee & Johnstone, 2021). It is unclear to what degree racialized people and communities experience inequities within Canadian healthcare, as health-related data are not stratified by race, which obliterate the lived experiences and struggles of racialized individuals and communities with the pandemic (Lopez & Neely, 2021). To care ethically in data collection regarding the COVID-19 pandemic requires sensitivity to the contexts, responsiveness, and attentiveness that are contextualized across differences instead of attending to the White norms that reinforce the unfairness of generating data as it is currently practiced (Raghuram, 2019).

Within the limited number of studies and writings about the hijab during the COVID-19 pandemic at the time of writing this dissertation, there are emerging voices pointing to the hypocrisy of the ban on face coverings in a time when the public is mandated to wear masks that cover a good portion of the face (Ricca, 2020). Syed (2020) lays out a similar argument that the ban on the niqab has become especially questionable since the beginning of the COVID-19 pandemic wherein most people are asked to wear face coverings to prevent the spread of the virus. The same rationale can be evoked on the hijab within healthcare settings. When covering one's hair is becoming a regular and required part of PPE, wearing the hijab should be considered a normal, clean, and safe practice. The tension between the hijab and ICP practices needs to be critically examined, especially within the context of the COVID-19 pandemic where hair covering has become a normal and sanitary aspect of nursing dress and is increasingly mandated. In other words, the practice of covering one's hair is becoming a part of the uniform of nurses as another layer of reducing the risk of infection. As such, the hijab warrants the same treatment and consideration.

Being Excluded from Leadership Positions

Racialized nurses are significantly underrepresented in Canadian nursing, especially at the leadership level and in areas of advanced practice (Premji & Etowa, 2014). Several barriers perpetuate this underrepresentation including racism through Othering and tokenism (Gupta, 2008, Vukic et al., 2012). Inherent in this exclusion is the power nursing managers hold not only as people in positions of authority but also as, most often, non-racialized managers who exercise their White privilege to exclude racialized bodies.

Institutional racism that is enacted through normalizing Whiteness and maintaining practices and policies that preserve the status quo perpetuate the exclusion of nurses who wear a hijab from working at the leadership levels, further disadvantage them, and create an unwelcoming work environment (Beard, 2020). As amplified by critical race theorists, racial stratification is embedded within the normalized functions of institutions that operate to produce and maintain structural racism and to preserve White hegemony through established practices and policies that are experienced by racialized people and groups (Delgado & Stefancic, 2001). Racism is a main barrier that discourages qualified and experienced racialized nurses from applying for leadership positions (Iheduru-Anderson, 2020). Iheduru-Anderson explains that maintaining “White comfort” functions as a barrier that prevents racialized nurses from obtaining leadership positions (p. 667). White comfort refers to a culture within nursing in which hiring managers cater to White nurses and attend to their comfort (Iheduru-Anderson, 2020). Maintaining White comfort is a suitable concept in understanding the lack of representation of racialized nurses at the leadership level where their education and clinical experience are rendered irrelevant when the goal is to maintain the comfort of White nurses within leadership spaces. Hiring practices by middle and upper-level nursing managers undermine appointing

racialized nurses into leadership positions due to what Beard and colleagues (2020) describe as “familiarity bias” in which managers tend to hire nurses “who look, think, and sound like them and appear to share similar worldviews”, and exclude racialized nurses who are ‘not a good fit’ and to deter them from applying for such positions (p. 176). Similar to the experiences of Muslim nurses who wear a hijab, Black nurses share experiences of being considered inadequate for advanced positions because their education and credentials were undervalued (Gupta, 2008; Iheduru-Anderson, 2020). Indeed, “[d]espite nursing’s ethical and social justice mandates, the profession as a whole has been unwilling to engage in public discourse and practices that address racism and discrimination among its rank and file” (Beard et al., 2020, p. 176).

The exclusion of nurses who wear a hijab from leadership holds multiple implications. It reaffirms the assumptions about them as undereducated and less competent and therefore, unable to move up the ladder, obfuscating the reality that they are prevented and systematically stopped from achieving such career goals. Therefore, as conveyed in Madiha’s narrative, this exclusion creates a vicious cycle that maintains White management and leaders who occupy and preserve White spaces within nursing while keeping racialized nurses outside such spaces (Hassouneh et al., 2012; Iheduru-Anderson, 2020). This vicious cycle operated to silence the voices of nurses who wear a hijab and to abort their participation in organizational policies and processes that shape their nursing experiences (Iheduru-Anderson, 2020; Prendergast et al., 2020). It also manufactured a lack of role models that nurses who wear the hijab can look up to and model after, which compromised their opportunities for professional development within advanced positions (Carter et al, 2015). Another implication was that qualified nurses who wear the hijab might be deterred from applying to leadership positions because of fear of being a token hire (Iheduru-Anderson, 2020). Finally, it reinforced racism within nursing and exemplified the

failure of the discipline to meet this moment in history and to stand true to its value of advocating for and working towards social justice.

5.2.3 Third Composite Narrative: My Story: Navigating Power Structures and Power Relations

My name is Yumna and I have been a nurse for over a decade. I have practiced in different Canadian provinces. I am also a Muslim woman who wears the hijab. I am clear on the fact that wearing the hijab was my own choice and I often communicate the meanings it holds for me. Wearing the hijab is very much a part of who I am and my identity. I chose to wear it because I believe it is an act of worship and doing so is how I interpret my faith. It is a sign of modesty, and it makes me feel complete and safe and respected in my space. When wearing my hijab, I feel and look beautiful too. As a Muslim woman, I care about how I look, and I can dress it and I can be fashionable. It makes me feel more confident as well, but the main thing is that when I choose to wear a hijab, it is about making that conscious choice to obey *Allah's* command. Usually, I am the only nurse wearing the hijab on any given unit. I take pride in being the only nurse wearing a hijab in a room because this might be the only experience that someone has with a Muslim woman, and it is nice that it is in the healthcare setting. With this, they can come to learn that Muslim women are everywhere, they are successful, and really in all fields in general. It's nice to be a part of that representation.

I try to take the questions that I regularly receive about my hijab and religion as teaching opportunities. I like to see this in a positive light most of the time. To me, it serves as a way of *Da'wah* in that I get asked questions like 'why do you wear it?' and 'what is it called?' I can provide education while presenting Muslim women. It is my belief that through being a good nurse and a good person, I can show the often-untold beauty of Islam. However, it can be challenging to address these questions, even when they are motivated by curiosity. Though I still think religion is a private and personal matter, I am not as put off or shocked when I get asked the questions as I once was, and I have gotten to the point where I know the questions to expect and how to prepare for them.

The other interesting and at the same time challenging aspect of my experience is the persistent feeling that, because I am a nurse who wears the hijab and a Black nurse, I always need to work harder than other nurses to prove that I deserve to be a nurse and to assert my normalcy. I have experienced this starting in nursing school. In clinical practice, I had to go above and beyond and, even in my fourth year, I had to consistently prove that I want to be a nurse and that I am competent, safe, and would like to take care of patients. I worked harder on my assignments. To reclaim control, I felt compelled to be successful to prove my normalcy and belonging, which takes away from that human aspect where I feel like I cannot have a bad day.

I often overcompensate by explaining things in full detail to almost prove my knowledge and put those I care for at ease. It says that I know what I'm talking about and I'm here to support you. It's a pervasive need to justify my competence and belonging. On top of that, I am constantly vigilant of how I conduct myself and of how people around me perceive me. I am often in a state of guard, so I tend to smile way more than I need to, and I am always extra nice. I make a point of trying to wear makeup to work, and therefore, I am normal. And I make sure that I incorporate fashion into my hijab. I have made adjustments by intentionally choosing tiny hijabs with my scrubs, so I put to rest the voiced concerns that a patient could get a hold on my hijab and use it to strangle me. I again made a point of wearing a different hijab with a different color each day to visually demonstrate that my hijab is clean and that it is washed and changed daily so I avoid being singled out and talked to about the risks my hijab holds in the eyes of infection control. All this was a huge reason as to why a year and a half ago or two years ago I did have a huge inclination or desire to take off the hijab, but Alhamdulillah, I surpassed that difficult time.

I am also aware of when to enact silence, of the need, at times, not to engage in the conversations around me and to keep my thoughts to myself. I have seen nurses get frustrated, I've seen doctors get frustrated, I have seen doctors raise their voices, and I have seen nurses raise their voices when they are talking passionately about something. But if I did that, if I got frustrated, I am the angry Black, Muslim woman. While at work, I am aware that my colleagues can talk politics, current events, and more. I cannot have those conversations because it is not appropriate.

I represent an entire group, though I am just one person with my own experiences and views and opinions. Recently, a topic came up about the Coronavirus and the Black Lives Matter protests. Some of the nurses I work with called these protests ridiculous and should be stopped as they pose a health threat. What do I say to that? I get the health concerns; I am a nurse working in a hospital during a pandemic; I do not want the ICU flooded with patients. At the same time, I am a Black woman who experiences racism. I understand why the protests are important. It may not be important to them because they do not understand our experiences and what we go through, but I do. My family members do. My friends do. So, I do not discuss politics and I do not talk about religion at work, I do not talk about current events and my views. I sit and listen, and I remind myself that I am not to engage in these conversations, that I choose to be silent.

Analytical Discussion

In this discussion, I focus on storylines from the third composite narrative, “My Story: Navigating Power Structures and Power Relations”. The storylines of the first two composite narratives are closely related to and intersect with those of this narrative which focuses on the everyday acts of resistance by nurses who wear a hijab through the uptake of strategies by the Muslim nurses to reclaim control and to navigate power structures within nursing. These acts of resistance “can vary depending on the social context of oppression, and they operate at the micro level of social organization” (Alimahomed-Wilson, 2020, p. 654). These strategies were enacted separately and collectively to claim control over the discourse on nurses who wear a hijab and to push against existing oppressive power structures. The nurses resisted their racialization through asserting the multiple meaning they hold for the hijab and by taking on the role as ambassadors of Islam. Further, and in agreement with Karaman and Christian (2020) and Selod (2018), to reclaim their control over their image and re-construct the narrative about them, the nurses actively controlled their dress and strategically chose to silence themselves.

Asserting the Multiple Meanings of the Hijab

Attending to the varied meanings of the hijab is essential as nurses who wear it practice within the Canadian context of rising anti-hijab sentiment and Islamophobia. Inevitably, this context shapes the ways nurses who wear a hijab perceive the world and the ways in which the world receives them. Specifically, events like the recent passage of Bill 21 in Quebec continue the legacy of discrimination against Muslim women and reinforce gendered Islamophobia in Canada through singling out the hijab as a foreign and a symbol of oppression and terror (Azam, 2020), while, for example, categorizing the crucifix as a valued aspect of culture and heritage (Gould, 2018). Highlighting the meanings of the hijab is also critical in presenting the voices of the nurses who wear it, as these nurses practice within the discipline of Canadian nursing and its prevailing history of systemic racism and discriminatory practice towards racialized nurses (Calliste, 2010; Hilario et al., 2018; Thorne, 2017).

The nurses, through sharing their stories, assigned a complex array of meanings to their hijab, indicating their heterogeneity. This diversity also challenges the essentializing narrative that often negatively portrays the hijab. Integral to the discussion on the hijab is the understanding that it carries diverse meanings, often dependent on the individual values of the women who wear it and on contextual factors. In this vein, while reiterating the ways in which the nurses who wear a hijab find agency and beauty from the hijab, it is also important to note that this finding is expected, considering the heterogeneity of the nurses who participated in this study. This finding also has been supported by many studies and writings on the hijab and on women who wear it (Afshar, 2008; Ahmed, 2011; Frank, 2000, Galadari, 2012; Hoodfar, 1993, 2003; Hyder et al., 2015; Jamal, 2011; Litchmore & Safdar, 2016). Nevertheless, I opted to discuss this finding to illuminate the voices of the nurses in this study, to push against the

persistence of the negative meanings assigned with veiled Muslim women, and to continue the work of other scholars who challenge the Orientalist and colonial framing of veiling.

The meanings of the hijab articulated by the nurses were a combination of the hijab as an act of worship by obeying the command of *Allah*, an expression of the Muslim identity, a means of asserting modesty and negotiating public space, and as an expression of beauty and fashion. These meanings are also articulated by many Muslim women (Litchmore & Safdar, 2016; Ruby, 2006; Zine, 2006). The hijab is also characterized as a source of empowerment in which women who veil establish a moral boundary between themselves and the outside world by claiming and defining their personal space (Furseth, 2011). Like the nurses in this study, participants in several studies on Muslim women identified the hijab as a means of exerting control over their bodies when negotiating public spaces and as protection from sexual objectification (Litchmore & Safdar, 2016; Ruby, 2006; Siraj, 2011; Zine, 2007).

The hijab was also described by the nurses as a source of modesty, beauty, and fashion. Indeed, the hijab as a representation of modesty does not conflict with the notion of the hijab as a fashionable garment. Michelman (2003) argued that “the acts of being modest and fashionable are not necessarily two mutually exclusive behaviors” (p.79). Hijab as a fashionable piece of clothing challenges the idea that modest dress is incompatible with being fashionable (Michelman, 2003). Similarly, the hijab as a source of beauty stands in clear contrast to its presentation as unfeminine and backward (Richards, 2016).

In reading across the stories of the nurses, the overlap and interconnectedness between the meanings of the hijab was clear. What was also palpable is the intensity of the gaze and the continuous surveillance of the nurses’ bodies. Across the nurses’ stories, wearing the hijab was a

representation of their identities as Muslim nurses in a workplace where nurses who veil remain a minority.

Acting as Ambassadors of Islam

Another strategy the nurses employed to navigate power structures and power relations was to conduct themselves as ambassadors of Islam (Selod, 2018). The nurses took pride and found empowerment in holding onto their Muslim identity and using their position as nurses who wear a hijab to change the perception of Muslim women. The act itself of wearing a hijab was a way of enacting the agency of the nurses. Spivak (1988) concludes that the subaltern cannot speak but this religious signifier can allow for voice and agency of the nurses who wear it as well as their experiences with Islamophobia to be articulated and shared; it is also a testimony to how power/privilege and disadvantage can operate simultaneously within the experiences of the nurses.

Though being the only nurse who wears a hijab in the workplace was challenging as it further contributed to the Othering of the nurses, they saw themselves as representatives of Islam and Muslims. The nurses executed the role as ambassadors of Islam by directly speaking about their religion and what it means to further educate their patients and their colleagues and to disrupt the unfounded assumptions about their religion and about them. They utilized the frequent questions they encountered about their religion and their hijab as a form of '*Da'wah*', an Arabic word that refers to explaining and demonstrating how Islam works for believers. By answering these questions and by demonstrating their competency as nurses, they seized educational opportunities.

By conducting themselves professionally and proving that they are trustworthy, caring, and competent, the nurses resisted and mitigated their racialization by actively working to correct the stereotypes about them and to introduce facts about themselves that challenge their homogenized portrayal. In this way, the nurses saw their situatedness as nurses who wear a hijab as an opportunity to educate, to explain what their hijab meant to them, and to push against falsehoods about women who veil. The nurses also described how they worked hard to establish their competence and safety as nurses. Hence, these nurses pushed against the systemic structures and powers rooted in nursing education and practice that put forward the ideal of the ‘White good, Christian nurse’ constructed at the expense of nurses who do not fit within this mold. By working hard, the nurses asserted their competence and their goals of advancing their careers (Iheduru-Anderson, 2020).

In response to how their bodies were surveilled, as ambassadors of Islam, the nurses engaged in self-censure by controlling their behavior and actions. Van Es (2017) goes beyond doubting the efficacy of this strategy of censoring the self to warn that it is a form of “self-essentialization where the women reduce their identity to a single element - namely that of being Muslim - and where virtually every aspect of their everyday life becomes politicized” (p. 388). Though the intent by nurses who wear a hijab to self-censure is inherently powerful, there is a danger in constantly surveilling oneself. As demonstrated in their stories, self-censure was a means of mitigating the assumptions placed on the nurses by virtue of their hypervisibility as Muslim women. Inherent to this, as argued by Van Es, is the risk that the nurses who wear a hijab reduced their complex identities to that of simply a ‘hijabi nurse’. In doing so, there is further risk that the actions and interactions in their daily practice may be guided by the gaze they themselves have internalized. Indeed, the Western representations of the hijab that

homogenize and reduce Muslim women and the “projection of gender oppression onto Islam, specifically onto the bodies of veiled women” serve to normalize Western womanhood as a positive reflection against the negative image of the veiled Muslim women (Al-Saji, 2010, p. 877).

While acknowledging the power the nurses who wear a hijab reclaimed in their role as ambassadors of Islam, the nurses’ experiences captured the tension women who veil navigate daily. They must contend with the coexistence of their hijab as a private religious practice and its social expressions and public representations (Koura, 2018). While holding onto the private meanings of their religion and their hijab, the nurses were thrust into public discussions and explanations about their religion and religious dress. Selod (2018) explicates this conundrum experienced by Muslim women who veil who, by the virtue of their visible religious identity, are placed under the public gaze and must endure the hostility and discriminatory actions this gaze makes them vulnerable to. Interactions and exchanges such as those shared by the nurses in this study were emotionally and mentally onerous for the nurses who were made responsible for explaining themselves and their religion while simultaneously representing Islam and Muslim women. Consequently, Muslim women who veil face the burden of negative stereotypical representations of them within the political and social discourses that have become internalized in various aspects of Canadian society (Alimahomed-Wilson, 2017).

In the face of their hypervisibility and vulnerability, these nurses honored the practice of veiling and embraced their Muslim identity, effectively demonstrating their agency, self-confidence, and resilience despite facing intersecting forms of discrimination and interpersonal and structural power imbalances. In this way, the nurses have continued to actively push against and to resist the stereotypical homogeneous assumptions surrounding Muslim women who veil.

Reclaiming Control

The stories of the nurses revealed their ongoing effort to reclaim control over their image and re-construct the narrative about them. The nurses mainly leaned into the strategy of controlling their dress as a way to reclaim control over the constructed narratives about them. They also chose to silence themselves. Selod (2018) argues that controlling the dress is an approach Muslim women use to navigate and resist their racialization. Controlling the dress takes different forms, from removing the hijab to delineate their invisibility to altering the hijab. Removing the hijab is a means to eliminate the constant gaze over the bodies of women who veil and to alleviate the demand on them to constantly navigate the perceptions placed upon them. Though none of the nurses in this study have removed their hijab, which could be explained by the inclusion criteria, contemplating its removal was articulated by the nurses to mitigate their hypervisibility and to diffuse the unwarranted attention their hijab attracted. Evidently, contemplating removing the hijab was in part motivated by the pervasive pressure the nurses felt to prove themselves, demonstrate their knowledge, validate their education, and to gain the trust of patients, families, and other nurses. The compulsion to overcompensate in this way was articulated by the nurses as exhausting and taxing. Therefore, considering removing the hijab was inseparable from the desire to become invisible and to normalize oneself.

Controlling the dress also took the form of re-signifying the head cover by deliberately incorporating fashionable trends into the hijab to contrast with the traditional head cover. Wearing brighter colors, for example, resisted the Western conception of the hijab as a dark or black garment that symbolizes the oppression of those who wear it (Jouili, 2009). In controlling their dress, the nurses were conscious about incorporating fashion into their hijab along with wearing makeup to display their normalcy and push against the association of the hijab with the

images of traditional, oppressed, and outsider women (Van Es, 2017). The nurses also controlled their dress within the contexts of nursing education and the construction of the hijab as an unclean safety hazard by opting to wear a smaller hijab and by changing its color daily to visually demonstrate safety and cleanliness.

Using Selod's (2018) deconstruction of the complexity of controlling the dress among Muslim women, I argue that in doing so, the nurses reclaimed their agency in asserting control over how their bodies were imagined, pushing against the negative narratives about them, and actively demonstrating that their hijab is not a threat and that the nurses who wear them are not oppressed. On the other hand, controlling the dress revealed the imbalanced power dynamics at play. The constant surveillance of the bodies of nurses who wear a hijab does not occur in a vacuum; it is embedded within interpersonal relations and institutional structures that perpetuate and reinforce the negative portrayal of the hijab and nurses who wear it. In other words, those who turned the gaze on nurses who wear a hijab and constantly surveilled their bodies were able to lean on structures and practices rooted in colonialism and maintained by neoliberalism and the policy of multiculturalism that privileged them and enabled them to pressure the nurses to alter their dress to mitigate their surveillance and to limit their racialization.

The stories of the nurses underscored Van Es's (2017) argument that the intense scrutiny of women who veil makes them hyperaware of the perceptions the White dominant group holds about them and of the constant state of being surveilled. Thus, they internalize the gaze and surveil themselves. Van Es explains that changing negatively constructed stereotypes is a difficult if not an impossible feat. Stereotypes are constructed by enacting unequal power relations which, in this case, present Muslim nurses in unfavorable light while distinguishing any deviation from such construction as atypical rather than a positive representation of 'Muslim

nurses who wear a hijab'. When a Muslim nurse who wears a hijab is presented outside the stereotypical construction imposed upon her, she is not a reflection of a positive image of Islam and Muslim women. Rather, she is an exception to what is constructed about Muslim women.

Along with controlling their dress, the nurses chose to use silence as an approach to reclaim control. The silence/speech dichotomy, which is often enacted and embraced within the West, render silence as ineffective and absent in contrast to speech which is perceived as positive and empowering (Jungkunz, 2011). Jungkunz argues that a main flaw of this dichotomy is

... the assumption that silence as absence is always non-participatory, or inactive ... absence itself can be a form of insubordination, a refusal that can be quite powerful ... a resistance of the discursive structures or configurations that tend to manage the distribution of meanings that direct our lives (p. 5).

Jungkunz argues that, as a powerful strategy, "silence is used to disrupt speech that monopolizes; sometimes silence is used to protest injustice. Other times silence is deployed to break up relationships and unitary discourses" (p. 12). Silencing the self, therefore, is not about being ineffective or surrendering. It is empowering, as it does not reinforce racialized discourses and, silently, stands against injustices. In their own words, nurses who wear a hijab chose silence as a refusal to participate in discourses that further racialized them and propagated stereotypical assumptions about them.

Selod (2018) and Lems (2020) connect silencing the self as a strategy mainly to Muslim men who remain silent on their political views and current events out of fear of being associated with terrorism and to protect themselves from the devastating consequences of such association. Nevertheless, Karaman and Christian (2020), who studied the experiences of Muslim college

women in the US, found that silencing the self was a strategy most used by their participants to resist and mitigate their racialization and as a tactic to protect themselves in highly politicized and unsafe environments. Therefore, though silence can be conceptualized as powerful and as a form of speech, it is important to understand the nurses' choice of silencing themselves was enacted within the context of power imbalances in nursing that might render them silent and force them to refrain from expressing their views and from speaking up when experiencing or witnessing discrimination.

My goal in this chapter was to present the findings of the study as a counter-narrative in which Canadian nurses who wear a hijab to articulate their voices. The nurses' counter-narrative challenges the stereotypical assumptions about them and unveils the multilevel contextual power structures and relations that preserve racism within the discipline of nursing and reproduce the processes of racialization experienced by nurses who wear a hijab. In doing so, my aim was to provide a vessel in which the nurses could share their stories. From this emerged the ways in which these nurses reclaimed control over the narrative about them and resisted their racialization. Having presented the nurses' counter-narrative, which I placed alongside what is known in the literature, I now move to discuss the key implications of this study that would guide and inform nursing research, practice, policy, and education, as another facet of enacting transformational change in all aspects on nursing within an anti-racist framework.

Chapter 6: Limitations and Implications

6.1 Introduction

Framed by CRF and care ethics, and grounded within as intersectional analysis, this study is a critical examination of the experiences of nurses who wear a hijab to provide a point of resistance for the nurses by sharing their counter-narrative. The findings of this study fill a knowledge gap in the literature about the experiences of the nurses within the current highly racialized political environment that pairs Muslims with terror and violence. Further, a goal of the study is to decolonize nursing and to speak against racism; though it is known that racism exists in nursing, the unique experiences of Muslim nurses who wear a hijab have not been highlighted. When exploring their experiences, their stories reveal and challenge institutional and systemic forms of racism that still operate within Canadian nursing, supported by ongoing settler colonialism, failing multiculturalism, and harsh neoliberalism. The findings of this study suggest that moving forward requires a re-orientation of nursing policy, practice and education that is anti-racist in nature to shift nursing from a discipline of unequal powers to one that turns the gaze on itself to examine the structures and the processes that have maintained the status quo, with the goal of enacting the principles of care ethics. It is my hope that this study can contribute to future learning and education. In this final chapter, I first discuss the limitations of the study and move to provide recommendations for nursing research, practice, policy, and education, and I end with my concluding remarks.

6.2 Limitations of the Study

As with any research, this study has a number of limitations. My initial intent was to include nurses (RNs, RPNs, and LPNs) who wear a hijab and practice in hospitals and

community settings who provide direct patient care and work in leadership positions. The study sample consisted of eight registered nurses, one registered nurse who holds an advanced nursing degree and one LPN. This study included Muslim nurses who work in various Canadian provinces and in different clinical settings providing direct patient care. However, there was no representation among the sample for RPNs who usually practice in mental health settings. The sample also did not include nurses who work in leadership or at managerial levels. Therefore, their voices were not captured in this study. The absence of nurses at the leadership level from the sample can be explained by the underrepresentation of Muslim nurses and racialized nurses in general within leadership and middle and senior nursing management roles. As I noted before, the recruitment for this study extended over the first few months of the COVID-19 pandemic, which might have been an obstacle to participation in the study as nurses, among other healthcare providers, were struggling with stress from the pandemic, burnout, and increased workload (Brophy et al., 2021).

In alignment with Riessman's (2008) approach to generating narrative data, I asked the nurses who participated in the study a general question about their experiences as nurses who wear a hijab without directly or specifically proposing the question about their experiences with racism. However, the interviews generated experiences with both overt and covert racism during nursing education and at practice settings, which is unsurprising considering the documented experiences of Canadian Muslim women who veil and the prevalence of racism within Canadian nursing (Gupta, 2008; Nagra, 2017). Further, the subjectivity inherited in self-reported experiences, though can be seen as a limitation from a positivist stance, is a strength of this critical narrative study that aims to document the stories of nurses who wear the hijab as a way of communicating their experiences. Indeed, Harding (1991) argues, objectivity and socially

constructed knowledge are not mutually exclusive. She explains that broadening the base from which knowledge is constructed by exploring the experiences of women enhances objectivity.

Expanding the inclusion criteria of this study to include other female healthcare providers who wear a hijab, such as physicians, occupational health therapists, physiotherapists, and social workers, could have enriched the analysis by providing comparative contexts to nursing. However, by restricting the inclusion criteria to nurses who wear a hijab, my aim was to contextualize the experiences of the nurses, which, as I argued earlier, are shaped by the context of the nursing discipline. Also, excluding nursing students from participating in the study is another limitation, as their experiences could have further enriched the analysis and the findings. Yet, this limitation was somewhat mitigated as the nurses in the study shared their experiences as students.

Lincoln and Guba (1985) assert that the ability to transfer research findings and methods from one group to another determines the applicability of the findings to other groups. My intention in designing and conducting the study was not geared to ensure the generalizability of the findings to other groups of nurses or other populations. My intention was to describe the experiences of nurses who wear a hijab as a specific group of nurses. Nevertheless, many of the narratives in this study resonate with broader discourses on racialized women and with the documented experiences of racialized nurses, such as Black nurses and internationally educated nurses, raising the possibility that the finding can be transferred to other groups of nurses.

This study offers valuable lessons for future nursing research, practice, policy, and education. It is important to note the inextricable link between the different arms of nursing (research, practice, policy, and education). Hence, there is an overlap in the implications of this

study across these different aspects of nursing. This interconnectedness means that changes from within nursing should account for all aspects of nursing when enacting its commitment to social justice instead of hiding behind its values as cover for its denial of racism.

6.3 Implications for Future Research, Practice, Policy, and Education

This inquiry contributes to the growing body of knowledge on racism within the discipline of nursing and on exploring the experiences of racialized nurses. It further highlights significant gaps in the literature and offers implications for nursing research, practice, policy, and education. The findings demonstrate evidence of racism within nursing at the individual and organizational levels that are experienced by nurses who wear the hijab within their educational and practice settings. The findings also illustrate how the nurses, as hyper-visible Muslim women, embraced their faith-based identity and showed agency, showcasing their resilience despite facing intersecting forms of oppression. The nature of racism as often illusive, and blatant, is rooted within the historical and sociopolitical contexts of Canada and is enacted by individuals, institutions, and the state, which makes it clear that there is no simple approach or strategy to tackle multilevel racism, including islamophobia. Dismantling racism requires the commitment of nurses and Canadian nursing to actions directed towards achieving social justice; a commitment that is attainable by decolonising nursing through addressing unequal power structures and policies and practices that perpetuate racialization processes (George, 2000). Hence, this study contributes to the decolonization of nursing, as it offers valuable knowledge to guide future research, nursing practice, policy, and education.

6.3.1 Implications for Future Research

While this study highlights the experiences of Canadian nurses who wear a hijab, it underscores several gaps in research. In their stories, the nurses included the harmful and lingering impacts racism had on them, which point to the need for research that investigates the potential psychological and physiological health implications on these nurses. Even though there is a reasonable body of the literature on the experiences of racialized nurses, the unique situatedness of nurses who wear a hijab indicates the need for further research examining the experiences of Muslim healthcare professionals, including students and men, to provide comparative, intersectional, and nuanced understanding that accounts for the contexts of multiple disciplines and the role of gender.

There is also a need for studies that examine the perspective of White nurses and nurse leaders in terms of their experiences working with nurses who wear a hijab. Another emerging area of research that requires attention is the experiences of nurses who wear a hijab within the context of the COVID-19 pandemic and how it has impacted their everyday practice. Future research is to further examine the strategies and coping mechanisms employed by racialized nurses, including nurses who veil, to resist, and stand against their ongoing racialization.

This study brings attention to the potential contributions of CRF as a theory to nursing research and knowledge generation. Despite the value CRF can bring to nursing research and knowledge, it has not been thoroughly utilized within nursing research, and only a limited number of studies within the health sciences that employ it to examine racial stratification and the experiences of racialized people (Graham et al., 2011). CRF is emancipatory in that it provides the theoretical space for racialized women, as well as racialized people, to document

their stories and the freedom to construct their own narratives (Jordan, Wilson, & Alsobrook, 2019). CRF offers researchers the theoretical grounding to examine the interplay of Islamophobia and colonialism within nursing to bring attention to the intersecting factors that produce and maintain anti-Muslim racism and to advance social justice. Further, nursing research grounded in CRF ensures that nursing knowledge does not privilege White Eurocentric perspectives and is inclusive of historically excluded standpoints. As well, CRF allows for the critical analysis of power structures and moves beyond the Black/White binary by providing an epistemological space that includes racialized and White feminist researchers who engage in critical race analyses. It also provides a theoretical approach for researchers to advance knowledge on how the intersections of gender, race, class, and other socially constructed differences produce and maintain inequitable power structures.

Finally, this study highlights the value of using the composite narrative approach to present contextualized, complex, and situated data from stories without fragmenting them into categories while protecting the confidentiality of research participants. This study also offers multiple implications for nursing practice, policy, and education.

6.3.2 Implications for Practice and Policy

The implications of the findings for nursing practice cannot be separated from implications for policy: institutional change requires formal policies and a commitment at the individual level to enact change. More to the point, care ethics “asks each of us to consider the stakes of what it means to live in an antiracist, caring democracy together” (Lopez & Neely, 2021, p. 7). Hence, processes within nursing to address racism necessitate working at different levels and employing adequate resources and funding.

The study's findings point to the importance of reorienting nursing practice and policy towards an anti-racist framework that aims for enacting transformational change and advancing social justice. Therefore, we must start by creating a supportive practice environment that promotes open and honest discussions about sensitive and difficult issues such as Islamophobia and settler colonialism. The findings of this study reemphasize the notion that racism is deeply rooted within nursing and ignoring it or denying its existence have only served to ensure its survival. Hence, within practice settings, there is an urgent need to create an open environment for dialogue on racism and its harmful effects. Moreover, racially based discrimination should be clearly outlined as unacceptable and reportable with clear steps and regulations.

The reliance of cultural competency within practice settings has proven to be ineffective in addressing racism and it can be argued that cultural competency has provided a cover for racism to continue to operate under the guise that 'being culturally competent' is the same as being free of racism. Hence, some claim that cultural competency is the 'new racism', as it has contributed to the Othering of racialized people and groups by employing an obsolete view of culture while using non-racialist language (Berger & Miller, 2021; Pon, 2009). Anti-racist policies and anti-oppressive interventions need to be implemented as a routine in every aspect of nursing practice to move beyond cultural competency policies towards addressing unequal power relations and everyday racism in nursing.

For anti-racist policies to be effective in creating a supportive and open environment requires offering all healthcare providers as well as managers and leaders ongoing education to attain knowledge and skills that prepare them to examine their own attitudes, beliefs, and values and to embrace a commitment to honoring diversity and the values it brings to practice settings. Hence, a pivot from the focus of culturally competent practice should be accompanied by

introducing and supporting self-reflexive practice, which offers a critical pedagogical approach to teaching and learning about racism (Gustafson, 2007). Self-reflective practice requires that healthcare providers examine their social locations and how they influence their attitudes and beliefs, impact their care, and dictate their relations and interactions with racialized bodies. Indeed, an important starting point for decolonizing nursing begins with the willingness of nurses to acknowledge their role in perpetuating oppression by engaging in oppressive acts, denying the existence of oppression, or by remaining neutral or silent while standing witness to oppression (McGibbon et al., 2014).

There is also a pressing need for equitable hiring and promotion policies and practices that are transparent and framed within an anti-racist and anti-oppressive lens. Hiring and promotion policies and practices are to be responsive to structural racism and to address the relationship between privilege and oppressive hiring practices that exclude racialized nurses while fostering tokenism. Further, supporting and mentoring after hiring is needed to ensure the success and the retention of nurses who wear a hijab, especially when hiring at the leadership and managerial levels where there is a lack of representation and mentors due to years of exclusionary practices.

This study underscores the importance of storytelling in communicating the experiences of racialized nurses and in promoting an awareness of the interplay of structural inequities and unequal power relations that shape their experiences. Consequently, storytelling should be embraced as an approach to generate knowledge, enact change, and evaluate success. Counter-narratives as a source of experiential knowledge need to be strategically positioned to inform nursing practice and policies, to challenge the infiltration of racism in nursing, and to decolonize nursing.

6.3.3 Implications for Nursing Education

Nursing education plays a fundamental role in shaping the nursing discipline. The close connection between nursing education and practice requires that “working toward decolonizing nursing includes a commitment to exposing colonizing ideologies, values and structures embedded in nursing curricula, teaching methodologies and professional development” (McGibbon et al., 2014, p. 186). Thus, settler colonialism and Islamophobia need to be openly discussed in nursing education by facilitating a dialogue that is founded on self-reflexivity and acknowledges individual and structural racism while refraining from the assumption that all White people are racist. Grounding such dialogue within the critical examination of settler colonialism, neoliberalism, multiculturalism, the current political climate, and the history of nursing provides the contexts for understanding the roots of racism and how it has continued to operate. Doing so avoids the superficial and context devoid discussion of racism within classroom settings. Nursing educators, therefore, are expected to have the capacity to teach about racism and to “reorient nursing pedagogy away from the discourses of individualism, multiculturalism and colour-blindness towards an explicit engagement with the institutional and ideological influences that structure health and social inequities” (Hilario et al., 2018, p. 5). Learning about and teaching settler colonialism, the different forms of racism including anti-Muslim racism should be mandatory in nursing curricula and integrated into the different levels of nursing education.

The importance of the historical and sociopolitical context to the understanding of the pervasive nature of racism, specifically anti-Muslim racism, underscores the utility of storytelling as a learning and teaching modality that honors experiential knowledge, gives voice to historically oppressed and silenced individuals and groups, and unsettles the compliance of the

dominant group. Telling stories advances our interest and situates ourselves and others within the social contexts that we experience (Bell, 2003). The strategic use of storytelling, particularly stories about resistance and transformation, is an effective tool in teaching about racism. Analysing such stories allows students to understand how people, from both dominant and oppressed groups, are positioned in ways that maintain the status quo.

Bell (2003) advocates for the use of stories in teaching to “help us be more conscious of historical and current realities, and through this consciousness, interrupt the stories that prevent movement toward a democratic and inclusive community” (p. 4). The uptake of storytelling within nursing curricula also requires teaching students about critical social theories, such as CRF, that privilege stories as a means of constructing and communicating experiences and attend to the role of gender and race in shaping experiences, while remaining attentive to other intersectional axes of differences.

An antiracist approach to nursing education promises to address the insidious harms of discrimination in the healthcare system, including in nursing, as noted in a recent report on Indigenous-specific racism within the Canadian healthcare system (Turpel-Lafond, 2020). As discussed previously, there needs to be a shift from a focus on cultural competency to anti-racist pedagogy through examining power structures and power relations that sustain individual and structural racism. An anti-racist pedagogy focuses on promoting social justice, using praxis to account for the broader contexts producing racism, and allows for the contextual understanding of racism. Indeed, nursing, particularly nursing education, is to renew its commitment to care ethics that is intersectionally oriented and clearly directed to achieving social justice.

Nursing is morally obligated to position itself within a care ethics that is rooted in relational ontology, sensitive to the contexts, and attentive to the interplay of race, gender, class, religion, and other axes of difference, and resistive to the values of neoliberalism that have fostered the denial of racism in its knowledge, practice, policy, and education. Therefore, there is a need for diversifying the nursing faculty and the student body, increasing the visibility and influence of racialized faculty in academia and leadership by ensuring that hiring and promotion policies are congruent with the goal of advancing social justice. Further, ongoing education and training of faculty at all levels is required to prepare faculty to counter the effects of settler colonialism and racism and to teach social justice-oriented curricula. Finally, there is a need for faculty to engage in self-reflexivity to examine their role in maintaining oppressive practices and to develop strategies and approaches that directly tackle Islamophobia and all forms of racism.

6.4 Concluding Remarks

This study contributes to a nuanced understanding of Islamophobia in Canadian nursing through illuminating the voices of nurses who wear a hijab which reveal structural processes of racism. This study is a response to the increased calls by nursing scholars to address racism within nursing and to critically examine the unequal power relations and structures that foster structural racism while attending to the contexts in which racism has continued to thrive. This study also contributes to the literature on intersectionality as it moves beyond the triad of gender, race, and class to examine the intersection of religion and how it influences experiences, as religion is enacted as a marker of difference rooted in settler colonization and the historical processes of exclusion in Canada. The experiences of the nurses who wear a hijab disclosed how they were racialized. These experiences revealed the infiltration of the discourses on Islam, and more specifically, on Muslim women who veil into the consciousness of individuals, institutions,

and the state and how they continue to deploy colonial Orientalist narratives to present them as a backward and violent in contrast to Christianity, as modern and rich in heritage, and civilised White Canadians.

Though calling out racism and unveiling its obscure nature in nursing are important steps, they are not enough. There is a pressing and urgent need for transformational change in nursing through anti-racist practices, policies, and pedagogy. In this, I stand with Koschmann and colleagues (2020):

Our call for antiracist nursing practice requires examining ourselves, the institutions where we work, and the racist policies that perpetuate health disparities and their social determinants. Rather than race neutral or culturally competent care, antiracist practice actively stands against racism. We must face the epidemic of racism head-on by applying rigorous changes to nursing practice, research, and education, and, as is always true with our profession, do this with empathy and respect (p. 540).

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Appendices

Appendix A

Questions for Screening Potential Participants

My name is Nasrin Saleh and I am a doctorate student at the University of Victoria, School of Nursing. I am conducting this research as a requirement for the completion of my degree. The research purpose is to understand the experiences of Muslim nurses who choose to wear a hijab within the Canadian healthcare system.

The purpose of the following questions is to see if you meet the inclusion criteria set for this study. As a potential participant, your eligibility to participate in the study will be screened through answering the listed below questions. You would meet the inclusion criteria of the study if you answer “Yes” to all of the questions (1 through 5).

1. Are you a registered nurse, licensed practical nurse, or a psychiatric registered nurse?
2. Do you identify as a Muslim?
3. Do you wear a hijab in practice?
4. Are you currently practicing in Canada?
5. As a nurse, do you practice within a clinical or leadership capacity?

If you do not meet the inclusion criteria, your contact information will be destroyed through deleting all electronic files containing contact information and shredding any contact information in paper format.

If you are successfully screened to be a potential participant, the next steps to obtain informed consent.

Appendix B

Recruitment Letter
THE UNIVERSITY OF VICTORIA

UVIC School of Nursing
PO Box 1700 STN CSC
Victoria BC V8W 2Y2
nursing@uvic.ca
Phone: 250-721-7954

**Applying Critical Race Feminism and Intersectionality to Understanding Muslim Nurses
Narratives of Wearing a Hijab in the Canadian HealthCare System**

April, 2020
Hello,

I am sharing this letter to communicate information regarding the study that I am conducting for my PhD dissertation, as a part of my doctoral degree at the University of Victoria, Nursing School.

The purpose of this research project is to understand the experiences of Muslim nurses who, in their day to day practice, choose to wear a hijab. Key objectives include examining the axes of social difference, e.g. gender and religion, within the healthcare system. Studies have shown that Muslim women who wear a hijab may experience increased forms of racialization and potential negative health effects when compared to Muslim men. However, a gap in knowledge exists on Muslim women who work in non-male dominated sectors. Bringing voice to Muslim nurses will inform how religious signifiers such as hijab as well as other axes of social difference, such as gender and race, may impact workplace experiences.

I would like to elicit your assistance to bring this study to the attention of nurses by posting the study's recruitment poster and sharing it on your organization's social media outlets. Nurses who are interested in participating in the study are to contact me directly. If you have more questions, please don't hesitate to telephone me at xxx-xxx-xxx or email me at nasrin@uvic.ca. You are also welcome to contact my PhD supervisor Dr. Nancy Clark at or at nancyclark@uvic.ca for further information. Also, if at any point, you are interested in discussing the findings of the study, I would be happy to connect via phone or email and would also welcome your feedback. Copies of any reports or publications from this study will be available to you upon request. Your help with this project is much appreciated. Thanks again for your interest and support.

Sincerely,

Nasrin Saleh RN, MPH, PhD(c)

Appendix C

Recruitment Poster
THE UNIVERSITY OF VICTORIA



UVIC School of Nursing
PO Box 1700 STN CSC
Victoria BC V8W 2Y2
nursing@uvic.ca
Phone: 250-721-7954

Invitation to participate in research study titled “Applying Critical Race Feminism and Intersectionality to Understanding Muslim Nurses Narratives of Wearing a Hijab in the Canadian Health Care System”

Principal investigator: Nasrin Saleh, PhD Candidate, School of Nursing, University of Victoria

Email: nasrin@uvic.ca

Phone: xxx-xxx-xxx

Supervisor: Nancy Clark, Assistant Professor, School of Nursing, University of Victoria

Email: nancyclark@uvic.ca

Phone: xxx-xxx-xxx

If you are a Muslim Registered Nurse, Licensed Practical Nurse, or a Psychiatric Registered Nurse who wears hijab and is currently practicing in Canada (in a hospital, clinic, or community settings, providing direct patient care and/or different clinical and leadership capacities).

This study might be of interest to you!

Purpose of the Research Study

The aim of this research study is to understand the experiences of Muslim nurses wearing hijab within the Canadian healthcare system. Key objectives include examining how religious signifiers such as hijab may affect workplace experiences.

By participating in this study, you will be able to tell your story and share your experience in working within the Canadian health care system. In addition, your participation will help us understand what supports Muslim women/nurses in the profession.

Time and Place

By agreeing to participating in this research you can chose when and how you would like to be interviewed (by telephone, Skype, or Zoom). The interview may take up to 60-90 minutes. If needed and you consent, a second interview over 60 minutes will be scheduled.

A follow up meeting may also take up to 60 minutes to validate the findings with you.

Contact

If you are interested in participating or would like to know more about this study, please contact Nasrin Saleh RN, PhD (Candidate) at nasrin@uvic.ca or at xxx-xxx-xxx

*** If you are reading this poster online and interested in participating in this research study, you should contact Principal Investigator at nasrin@uvic.ca or xxx-xxx-xxx and not post publicly, as this is best practice to maintain your confidentiality.**

Appendix D

Participant Consent Form
THE UNIVERSITY OF VICTORIA



**University
of Victoria**

UVIC School of Nursing
PO Box 1700 STN CSC
Victoria BC V8W 2Y2
nursing@uvic.ca
Phone: 250-721-7954

**Applying Critical Race Feminism and Intersectionality to Understanding Muslim Nurses
Narratives of Wearing a Hijab in the Canadian Health Care System**

I. STUDY TEAM

Principal Investigator: Dr. Nancy Clark
UVic School of Nursing
Telephone: xxx-xxx-xxx

Primary Applicant: Nasrin Saleh PhD (Candidate)
UVic School of Nursing
Telephone: xxx-xxx-xxx

II. INVITATION AND STUDY PURPOSE

You are being invited to participate in a study. You may choose whether or not to participate: the choice is entirely up to you and you cannot be required to participate if you do not want to do so.

This study is being conducted as a part of the requirements for a degree in Doctor of Philosophy in Nursing for Nasrin Saleh.

The purpose of this research project is to understand the experiences of Muslim nurses in their day-to-day practice. In particular, Muslim nurses who choose to wear a hijab are invited to participate in this study. The main objectives of this study are to understand the factors which support Muslim nurses in their health care practice. Studies suggest that Muslim women who wear a hijab in male dominated work settings experience discrimination and may have less access to social supports. Your voice is very important in understanding experiences of Muslim women in nursing and the factors which support their employment opportunities within health care practices.

If you are a Registered Nurse, a Licensed Practical Nurse, or a Psychiatric Registered Nurse; and identify as Muslim; you wear a hijab in practice; and you are currently practicing in Canada, we would be interested to learn about your experiences practicing within the Canadian health care system.

III. STUDY PROCEDURES

If you say 'Yes' to participating in this study, you will be interviewed by Nasrin Saleh to discuss your experience as a practicing nurse in a Canadian health care system. You have the choice to be interviewed over the phone, Skype or Zoom for an in-depth 60-90 minutes' narrative interview. If needed and if you agree, a second interview over 60 minutes would be scheduled. An interview time that works for you will be agreed upon. Examples of interview questions you will be asked are: Would you be willing to share your experience as Muslim nurse wearing a hijab? What does it mean for you to wear a hijab at your practice and in every day?

Also, your participation includes a follow up meeting over the phone, Skype, or Zoom for up to 60 minutes to discuss preliminary analysis of the interview data with you. This process is called member check and can increase validity of the findings in qualitative research. The interview(s) and the meeting will take place over the phone, Skype, or Zoom at a time that is mutually agreed upon and is convenient to you. Each interview

will be audio-recorded, if you provide permission. If not, only written notes will be taken. Interviews will be later transcribed for analysis purposes.

Please be advised that information about you that is gathered for this research study uses an online program located in the U.S. or a program that can be accessed from the US Zoom. As such, there is a possibility that information about you may be accessed without your knowledge or consent by the US government in compliance with the US Freedom Act.

Your participation in this research is completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or explanation. Participating in this research in no way affects your employment and all information is confidential. You have the right to request that the audio recording be stopped at any time, and to withdraw any information you do not wish to be included in the study. If you withdraw from the study, the information you have provided up to the point of withdrawal from the study will be used in the data analysis, unless you state that you wish to have it removed.

To make sure that you continue to consent to participate in this study, I will verbally and frequently remind you of the voluntary nature of your consent.

IV. STUDY RESULTS

The results of this study will be reported in Nasrin Saleh's graduate thesis and may also be published in journal articles and shared in conferences, presentations, and workshops. We recognize that there is the possibility that participants could be recognized by others whom they work with given the small number of participants who meet the criteria of participating in this study within recruitment sites. However, all efforts will be made to ensure that your identity will remain confidential as a pseudonym will only be used in any knowledge dissemination activities.

If you would like to receive a copy of the study with a summary of the results after the completion of the study, a report on the findings will be emailed to you if you consent and provide an email address.

V. POTENTIAL RISKS OF THE STUDY

We do not think there is anything in this study that could harm you or be bad for you. Please be aware that your employment and other benefits to which you are entitled will not be impacted by your decision to participate or not.

However, sharing certain aspects of your experience might be upsetting. In the event you experience emotional or psychological discomfort during the course of the interview, you can take a 'time out', reschedule at another time, or withdraw from the study altogether. Counselling and support will also be offered to you through BC Public Service Agency. Your data will be discarded unless you give an explicit permission to allow for its continued usage.

VII. CONFIDENTIALITY

Your confidentiality will be protected. Your name and phone number obtained in order to contact you will be kept apart from the data and stored in a secure place in a locked office filing cabinet in Nasrin Saleh's office. Any electronic contact such as your email address and emails will be only accessed through a computer that is password protected and encrypted. Any identifiers will be removed from any of the data all forms of dissemination and pseudonyms will be used. Also, audio recording of your interview(s) and transcripts will only be shared with Nasrin Saleh's PhD supervisory committee and will be stored on a computer software file that is password protected and encrypted. Data will be stored for the duration of 5 years. At the end of the 5-year period, electronic files will be deleted, and transcripts will be shredded.

Your confidentiality will be respected. However, research records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the Human Research Ethics Office at

the University of Victoria and Fraser Health Research Ethics Board for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

VIII. CONTACT FOR INFORMATION ABOUT THE STUDY

If you have any questions or concerns, or would like further information, please contact Dr. Nancy Clark at xxx-xxx-xxx or nancyclark@uvic.ca, or contact Nasrin Saleh at xxx-xxx-xxx or nasrin@uvic.ca.

IX. CONTACT FOR COMPLAINTS

You may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca). Also, you can contact the Fraser Health Research Ethics Board Co-Chairs at 604-587-4681.

X. PARTICIPANT CONSENT AND SIGNATURE PAGE

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your [for example, employment, class standing, access to further services from the community center, day care, etc.].

- Your signature below indicates that you received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

Participant Signature Date

Printed Name of the Participant signing above
I do/do not (please circle) give permission for the use information provided for future studies conducted by the research investigators assuming that a future study is reviewed and approved through a university Ethics Review Committee.

Participant Signature

Participant Email Address
I do/do not (please circle) give permission for the research investigators to email me a copy of the study with a summary of the results after the completion of the study.

Participant Signature

Participant Email Address

Appendix E

Interview Questions Guide

Introduction

My name is Nasrin Saleh and I am a doctorate student at the University of Victoria, School of Nursing. I am conducting this research as a requirement for the completion of my degree. The research purpose is to understand the experiences of Muslim nurses who choose to wear a hijab within the Canadian healthcare system. I would like to understand your narrative about nursing in Canada. The idea is that you share your story wherever you want to begin. I have a few open-ended questions to help guide us and some prompts if we get stuck.

You have the right to skip any question or stop the interview at any time.

Interview Questions

1. I'd like to begin with asking you about your story, would you be willing to share your experience as Muslim nurse wearing a hijab?
 - a. Probe: you can start anywhere you like: e.g. how long have you been practicing in Canada....
2. What does it mean for you to wear a hijab at your practice and in every day?
 - a. Probe: Do you feel like you are singled out in anyway? If so how? If not what makes you feel like you are supported at practice?
3. Have you ever experienced any challenges related to wearing your hijab at work?
 - a. Probe: tell me more about that experience...what was the context?
4. Tell me a bit about your thoughts on accessing supports related to advancing in leadership jobs? Or what kind stance your organization has on equity and diversity in the workplace?

Probe: are there any specific policies that come to mind?