



A Japanese Canadian Nurse Reflects on Cultural Competency, Humility, and Safety in Caring for an Indigenous Patient

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Abstract

The effects of colonization in Canada continue to cause mistrust of the healthcare system among some Indigenous people. A Canadian registered nurse of Japanese and European descent reflects upon his final clinical placement as a student nurse, where he cared for an older Indigenous woman in North Central Saskatchewan. The concepts of cultural competence, humility, and safety were applied by reflecting upon the history of Indigenous people in Canada, as well as through the nurse's life experiences with Indigenous people. The nurse's own family history of Japanese Canadian internment during the Second World War was contemplated, and the discrimination facing his family after WW2. Lessons learned from reflecting on cultural competence, cultural humility, and cultural safety in clinical experiences will have implications for the health care system, the profession of nursing, patient outcomes, and my future nursing practice. Necessary changes still needed in the healthcare system in light of recent racial encounters are discussed.

Keywords: Indigenous, cultural competence, humility, safety, trauma-informed, internment.

The Canadian government currently strives for cultural and ethnic diversity in Canada, as evidenced by the 1988 *Canadian Multiculturalism Act*. According to Berry (2020), this

specifically included that multiculturalism is a fundamental characteristic of Canadian identity and that people from all ethnic and cultural backgrounds, shall receive equitable opportunities to help shape Canadian society. This sense of equality and freedom resonates within the nursing profession. As evidenced by the Canadian Nurses' Association (2018) *position statement, Promoting Cultural Competence in Nursing Care*, "In every domain of practice, nurses have an ethical and professional responsibility to respect and be mindful of the culture of each person in every encounter" (para. 1). However, Canada has not always been open to diversity. There are still those within Canadian society that do not believe in the importance of diversity and equality.

As nurses, it is essential that we encourage cultural diversity, as well as become educated and acknowledge historical discrimination, as well as the trauma that some Canadians still face to this day. A reflective paper assignment in my final *Transitioning to Nursing Practice* theory course provided the opportunity for me to reflect on a case scenario with a patient I cared for in my senior clinical placement. Through my interactions with this patient, I was to contemplate how the concepts of cultural competence, safety, and humility had implications for the health care system, the profession of nursing, patient outcomes, and my future nursing practice.

Case Scenario

The patient in this scenario was an elderly Indigenous lady, originally from a rural and remote area in Northern Saskatchewan, but had been living in an assisted living facility in the city for the last few years. I was assigned to this post-operative patient for only one day as I was not on duty again while she was on our unit. Report from the previous 24 hrs was that this patient was resistant to nursing care and refusing to eat. During the morning assessment, she had her nasal prongs out of position and therefore, had an oxygen saturation of 88 percent. I struggled to get her to keep the nasal prongs in, as she kept taking them out and yelling "mots", or "no" in Cree, and she spoke limited English. During the brief morning assessment, I concluded that some of the issues in this situation could be attributed to: (1) a young male nurse providing care to an elderly female patient; (2) a language barrier between the nurse and the patient; and/or (3) the possible effects of trauma due to history of colonization.

With regard to gender, in many global cultures, until the male gender of the nurse is accepted and respected by the female patient, it is difficult to meet nursing care goals (Prideaux, 2010; Vatandost et al., 2020). Therefore, I was aware I had to first gain her respect. Although my male gender may have been an issue with some older women, it seemed with this patient her behaviour was the same with female nurses too. So, I ruled that possibility out in my initial assessment.

Cree people are one of the largest linguistic and cultural groups of Indigenous people in Canada, their traditional territory extends from Northern BC to Northern Quebec and includes many different linguistic dialects. As to language, in my assessment, the patient did seem to understand English better than she could speak it, and I knew a few words in Cree. Also, our hospital had the resources of a licensed Cree translator on-call. (Archan et al., 2020; Blondin et al., 2019). However, these services may not be available for all the brief interactions occurring

between Indigenous patients and nurses in the course of 24-hour care. To begin with, I thought I would try to communicate using the few words I knew in Cree.

From my understanding of Indigenous history during the colonialization of Canada, one possible explanation for her behaviour is that due to historical trauma, she may have thought that I was trying to harm her. Her decreased oxygen concentration could have caused her to become confused, compounding the situation. I took the time to explain everything that I was doing, ensuring my body language was open and friendly, as was my tone of voice. I did this to build a trusting relationship with the patient and portray that I was attempting to help her. I attempted to show that I cared for her psychological, emotional, and physical wellbeing. According to a scoping literature review by Berg et al. (2019) entitled *Perspectives on Indigenous Cultural Competency and Safety in Canadian Hospital Emergency Departments*, “friendly approaches by the healthcare professional, as well as welcoming environments were shown to improve the nurse-patient relationship and changed the trajectory of the care experiences” (p. 137). I did not have a particularly good opportunity to ask this patient about her past experiences, as I only had her for one shift, as well as having three other patients at the time. Therefore, I functioned mostly on assumptions about this patient’s possible life experiences and the effects they may have had on her.

I tried to make my patient feel comfortable, by explaining that her oxygen was to make her feel better and heal. In an attempt to build a trustworthy relationship, as limited as my understanding is, I tried to speak a few words in Cree. In Cree, “Kohkum” means grandmother and from what I have learned, it is respectful to call a Cree grandmother “Kohkum”. In the Cree culture “Kohkum” is a title that is earned, and “Kohkums” are held in high regard. When I referred to her by her first name, as well as “Kohkum”, I noticed my patient left her nasal prongs on. I am not the first health care professional I have witnessed using an Indigenous language, to communicate with patients. I have on occasion, witnessed a few continuing care assistants, at a long-term care facility, use Cree to communicate with residents. While working there as a care assistant myself, I picked up some words and phrases, which I found helpful for communicating with people whose primary language is Cree.

When I brought my patient her morning medications, she refused to take them. But after explaining what they were and what they were supposed to do and stating the word “na”, she took her medication. “Na” means “here”, in the context of handing someone something in Cree. She only took a few bites of breakfast, as she refused to feed herself. But after I stated “Mitsu Kohkum”, or “eat grandmother”, in Cree, she was willing to continue eating with my assistance. By being friendly and respectful, by speaking in my extremely limited Cree, and by explaining that I was trying to help her recover and keep possible infections away, I built a trusting relationship with her throughout the day. According to Bharti (2019), “Indigenous languages have shaped the physical and spiritual aspects of Indigenous culture” (p. 1). This means that I showed respect for her culture by using her language to communicate with her to the best of my ability. When I said goodbye to her at the end of the shift, she even wished me goodbye and goodnight.

Indigenous History and Analysis of the Cultural Situation

The clinical scenario I chose to analyze is common in North Central Saskatchewan, having an Indigenous patient who is originally from a rural or remote community. Indigenous people comprise 4.9 percent of the national population (Statistics Canada, 2019). As the census is collected only every four years, in Canada, this percentage is based on the 2016 census. Unfortunately, 2016 is the most recent census, as to date the 2020 census collection has been delayed due to the necessary restrictions of the COVID-19 pandemic. The term ‘Aboriginal’ or ‘Indigenous’ is used by Statistics Canada (2020) to define people who identify as First Nations, Inuit, or Metis. According to Statistics Canada (2019), Indigenous people made up 16.3 percent of the population of Saskatchewan. Most of the Indigenous population resides in the Central and Northern areas of the province. In recent years Aboriginal people have been implementing and embracing the term ‘Indigenous’, therefore, I will use the ‘Indigenous’ term throughout this paper.

My client was in her eighties, and therefore there was a likelihood that she had attended a residential school, or had been a part of the ‘Sixties Scoop’. Both of which were Canadian government policies, where the government perceived Indigenous children would be better educated or cared for, if out of the control of, or taken away from their parents. I reflected upon this possibility and realized that in her post-surgical state of being in pain, in an unfamiliar, institutional setting, and being inadequately oxygenated at times, perhaps she was fearful, thinking that she was in an institution where we were trying to harm her physically, psychologically, and spiritually.

Colonization

Colonization has been ongoing for hundreds of years in Canada. According to Rahman et al. (2017), colonization began with the European notion of ‘terra nullius’, meaning that North America was deemed to be empty, and unoccupied by any ‘civilized people’ and therefore was up for grabs by colonial powers. This, as well as Treaties, and forcefully placing Indigenous people on reserves limited the land that Indigenous people had access to. Early Christian missionaries deemed Indigenous people human enough to receive conversion, but not human enough to warrant full recognition of their rights to their own lands and as sovereign nations (Miller et al., 2020; Rahman et al., 2017). This limiting of land restricted cultural practices, religions, and ways of making a living. The extent of which caused starvation and disease to become rampant in many Indigenous communities. The *Indian Act* of 1876 stated that First Nations people specifically were now wards of the state and that the federal government had the right to control a large amount of what occurs in their lives. This also implemented a generic chief and council government framework on First Nations across the country, eradicating the traditional forms of government each nation already had in place. The *Indian Act* of 1876 also outlawed cultural practices and traditional spirituality, which were punishable by incarceration (Rahman et al., 2017).

Residential Schools

Residential schools were in operation from the mid to late 1800s until 1996. The Canadian government policy included the forced removal of Indigenous children from their home communities, often with children spending their entire childhoods at these institutions (Miller et al., 2020). Sanitation was extremely poor at these institutions, leading to a high death rate from tuberculosis as stated in the 1907 Bryce report. According to Hay et al. (2020) “Bryce released a report outlining that of a total of 1,537 pupils reported on 25 percent had died, with one specific school having a mortality rate of 69 percent. At every institution almost every cause of death was tuberculosis”. The structure of residential schools, with many children sharing a small living space contributed greatly to the spread of TB. According to Wilk et al. (2017), this has led to an increase in substance abuse, mental health issues, infectious diseases, and overall poorer health among the survivors, as well as their descendants today.

Enfranchisement

Until 1950, First Nations people lost Indian status if they served in the military, graduated from University, or became ministers or priests. Until 1961, Indigenous people were denied the right to vote (Rahman et al. 2017). This process was called enfranchisement. In addition to this, Indigenous women who married non-Indigenous men, as well as their children lost their status. Non-Indigenous women who married Indigenous men, and their children, gained Indian status (Miller et al., 2020; Rahman et al. 2017). This was a paternalistic process based on European cultural norms, while many Indigenous societies were traditionally maternalistic in nature.

Due to the colonial history in Canada, and especially how colonial society has highlighted ways in which Indigenous people were different from settlers has created resentment and misunderstanding of Indigenous people to this day. They were made to appear and feel inferior and subhuman. There are still myths and misinformation passed along in Canadian society regarding Indian status and perceived benefits surrounding it. Therefore, many Indigenous Canadians are still treated as ‘second class citizens’ by many other Canadians; treatment, which I believe is unfounded, immoral, and unjust.

My Personal Lived Experience as a Japanese Canadian

My family was part of a marginalized population at one time as well, where their race, language, and cultural differences were looked down upon by Canadian society. My own family was involved in a traumatic set of events, known as ‘Japanese Canadian internment’. Robinson (2019) explained that internment was the forcible expulsion and confinement of ethnic Japanese during the second world war (WW2). My Japanese Canadian grandmother’s family was interned in Greenwood, BC during WW2. Their family along with 22,000 other Japanese Canadians within one hundred miles of the west coast were forcibly uprooted from their home in the predominantly Japanese Vancouver suburb of Steveston and exiled to rural areas of BC and elsewhere. I was told that without any charge(s) or due process, they were forced to leave their homes and could take only as many of their personal belongings as they could carry with them.

My great-grandfather's commercial fishing business was annexed, as well as their family home, and all other belongings they were not able to carry with them, were seized and auctioned off by the federal government. They were considered 'enemy aliens' despite the entire family being Canadian citizens long before the war started. My grandmother was three years old at the time when Japanese Canadians were deemed a threat to national security by the federal government of Canada. This sentiment was not shared by all of those in positions of power at the time. According to Marsh (2016), Major-General Kenneth Stuart, leader of the Canadian Army, was quoted as saying; "From the Army point of view, I cannot see that Japanese Canadians constitute the slightest menace to national security" (p .1).

My great-grandmother was forced with her few remaining small children at home, into a decrepit, cockroach-infested old building in Greenwood, BC, with other interned families. They were not allowed to leave Greenwood, and the only school that would accept Japanese Canadian children was the Catholic school in that town. My great-grandfather had to work long hours, for little pay as a cook in a logging camp in Northern BC, located hundreds of kilometres from his interned family. The fishing business, boats, and family home were never returned to them after the war. In 1988, Japanese Canadian Redress was reached; each surviving member of my family received \$20,000. However, this does not address the issues of the Japanese Canadian community on the west coast being scattered to the wind, and many descendants of the interned losing cultural identity, language, traditions, and social norms of their ancestors due to the destruction of the Japanese Canadian community.

Despite the surrender of Japan to the United States on September 2, 1945, the federal government gave Japanese Canadians still located West of the Rocky Mountains an ultimatum. This ultimatum was to move east of the Rocky Mountains or face deportation. My ancestors were part of the 10,000 Japanese Canadians still within British Columbia who refused to move. The Catholic mission in Greenwood advocated for the Japanese living there, and my grandmother's family was allowed to stay. According to Robinson (2017), the 4,000 Canadian citizens of Japanese racial origin were forcefully deported back to Japan between 1945 and 1949. Japanese Canadians were not allowed to return to the west coast of BC until 1949.

I grew up in a tight-knit and relatively traditional Japanese Canadian family with values focused on the importance of family and respect for your elders, as my grandmother is ethnically Japanese. I was born and raised in a small mining town in British Columbia (BC), where I was one of only four people who were visible minorities in my class. I was bullied and singled out for my ethnic background, as well as receiving the stereotypical responses that other Asian Canadians face. As a result, I often felt ashamed of my ethnic background as a teenager and tried to distance myself from Japanese-Canadian cultural values and norms.

I applied to the University of Saskatchewan at the age of twenty, as my partner at the time, who herself is First Nations and was from Saskatchewan. For almost two years when I first moved to Saskatchewan, I lived with my former partner's family. I embraced their culture by being curious and wanting to learn about their values, history, and social norms, and applying

this knowledge. My partner had also been exposed to different Indigenous cultures, as she is Mohawk, Dakota, and Cree. I respected their culture, with her immediate and extended family defining me as family.

I can say that my partner's family were very generous, kind, and supportive. I met people who experienced residential school and heard some of their stories. Residential school is another disgraceful, and appalling part of Canada's history, and continues to affect Indigenous health and wellness to this day. I have been invited to, and participated in sweat lodge ceremonies, as well as traditional feasts and smudging ceremonies. In my degree program, one of the prerequisite courses was Indigenous studies. In addition to this, we had the opportunity to have Elders come and speak to us about traditional medicines and their life experiences. The teachings of the Elders helped me to understand their culture and reflect on my own culture and values. Through my life experiences, I have learned how sacred tobacco, sweetgrass, and sage are important to some Indigenous cultures. I respect traditional teachings about giving thanks by putting down tobacco after taking anything from the land or water such as fish or berries; it made sense to me and is the respectful thing to do. I have always attempted to be respectful of other cultures, in this case, Indigenous people, as I understand how it can feel to be looked down upon because of your ethnic background, stereotyped and judged on that and not your character or ability.

Key Cultural Concepts

The concepts of cultural competence, cultural humility, and cultural safety are key concepts for health care practice in an increasingly diverse Canadian patient population. The steps of intercultural care are often best understood as the progression through the following: cultural awareness, cultural sensitivity, cultural competence, cultural humility, and finally cultural safety.

Cultural Competence

Learning about the history, social norms, and how to respectfully interact with people from cultures different from your own is an important part of cultural competency. As stated by Stubbe (2020) "cultural competency emphasizes the need of healthcare systems and providers to be aware of, and responsive to, patient's cultural perspectives and backgrounds. With cultural competency, patient and family preferences, values and cultural traditions, language and socio-economic conditions are respected" (p. 49). Cultural competency needs to be a requirement for healthcare professionals, especially due to the European-Canadian institutional settings in which many healthcare professionals operate. This is important today, as according to Statistics Canada (2017), "21.9 percent of Canadian citizens were born outside of Canada, with most immigrants coming from South East Asia, the Middle East, Africa, and the Caribbean Nations" (p. 1).

Cultural Humility

Cultural humility should be the focus of all healthcare professionals. According to Ruud (2018), "cultural humility consists of continuous self-reflection and education in which

healthcare professionals gain an awareness of their judgements and biases that can lead to health disparities of visible minorities and vulnerable populations” (p. 256). This is important for healthcare professionals to practice, as it can allow them to recognize that a patient may have or continue to experience adverse events due to their racial or cultural background, and therefore they may become hesitant to seek healthcare. Consequently, this may affect the patient’s overall health and wellbeing. Hospitals in Canada are government operated and regulated, and therefore are a Canadian-European construct. To better serve clients who are Indigenous or are from a marginalized background, equity should be the goal, not just equality. An appropriate definition for health equity in this context was stated by Braveman (2017) “Health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups” (p. 3). Cultural humility is an important first step for health care professionals in building empathy and therefore a friendly working relationship with marginalized groups of a different ethnic or cultural background than themselves, especially if this marginalized group is highly stigmatized within society.

Cultural Safety

Cultural safety is closely tied to humility, but according to Curtis et al. (2019), also includes “being aware of difference, decolonizing, considering power differentials in relationships, implementing reflective practice and letting the client determine if a clinical encounter is safe” (p. 13). I believe that cultural competency is important for understanding different cultures, but cultural humility and safety allow for an improved relationship and partnership with the individual patient.

Implications of Cultural Competence, Humility and Safety

This section will address the implications of cultural competence, cultural humility, and cultural safety on the four areas of the health care system, the profession of nursing, patient outcomes, and my future nursing practice. Contemporary racism of Indigenous people in the healthcare system, as well as people of East Asian descent during the COVID-19 pandemic have been a recent focus in our society.

Health Care System

According to Wakewich et al. (2016), “distrust of the Canadian healthcare system was cited as a part of the legacy of colonization. Control over health services has been paternalistically managed by federal authorities, leaving communities feeling excluded from decisions about their own health and wellbeing” (p. 374). This is possibly why my patient was resistant to taking her regular medications, having nasal prongs in her nose, and refusing food. We can expect experiences that she would have gone through if she had attended residential school, which could cause distrust of any European-Canadian institution, including the hospital setting. This is especially true if she had her hair cut off, was given medication to be de-loused, and was abused, all while being told this mistreatment was all to benefit her. Now, my patient

can take control by saying no or refusing treatment when she does not feel comfortable or does not understand how procedures will help her.

Racism

One of the areas of Canadian society in which Indigenous people continue to feel ostracized is in accessing healthcare. “Research has shown that racism against Indigenous people in the health care system is so pervasive that people anticipate racism before visiting the emergency department and, in some cases, avoid care altogether” (Browne et al., 2011, Kurtz et al., 2008, Tang & Browne, 2008, as cited in Canadian Nurses Association [CNA], 2018, p. 4).

Cases of racism in Canada’s health care sector concerning Indigenous people have been well documented in the media. Recent and ongoing events have brought renewed attention to the harms of Indigenous-specific racism. For example, a Facebook recording of events surrounding the death of Joyce Echaquan, a 37-year-old Atikamekw woman in Quebec in late September, 2020 (Godin, 2020; Lowrie & Malone, 2020). Another example is the ongoing investigation into the 2008 death of Mr. Brian Sinclair, who suffered for 34 hours in a Manitoba emergency waiting room without being seen before dying due to a urinary tract infection secondary to a blocked catheter (Geary, 2017; Puxley, 2013). There are countless other instances of Indigenous people experiencing racism in the healthcare system which is either not reported or are not published by the media. These situations contribute greatly to mistrust of the healthcare system, perhaps contributing to my patient’s behaviour in the case scenario.

The COVID-19 pandemic has seen a significant increase in hate crimes targeting people of East Asian Descent. One incidence under investigation is the attempted murder of a Burmese-American family. According to Tessler et al. (2020) “the suspect stabbed the father, a four-year-old and a two-year-old child because he ‘thought they were Chinese, who he felt was responsible for infecting people with the coronavirus. According to Gover et al. (2020), “the 2020 data on hate crimes in the USA are expected to be released in late 2021” (p. 658), therefore, no official national statistics are available currently. This increase in hate crimes is not unique to the USA, as the Vancouver Police Department (2021) has reported “a 717% increase in anti-Asian hate crimes from 2019 to 2020” (p. 2). In Saskatoon in March 2020 for example, a 15-year-old Asian boy was verbally assaulted with racial slurs, then physically assaulted, being tackled off his bike, and being punched in the head by a fully grown adult man. According to Tessler et al. (2020), the COVID-19 pandemic has revealed the negative perceptions of Asian Americans and Canadians that have long been present since the ‘Yellow Peril’ of the late 19th century to the mid 20th century. The ‘Yellow Peril’ consisted of the Western fear of non-white Asian invasion and domination. “In March 2020 it was reported that 30% of people have witnessed someone blame the COVID-19 pandemic on Asians” (Tessler et al., pp. 637–638).

Trauma-Informed Care

According to Oral et al. (2015), a “trauma-informed healthcare system recognizes the extensive impact of trauma and understands potential paths for recovery, recognizes the manifestations of trauma in clients, and responds by integrating knowledge about trauma into practice and seeks to avoid re-traumatization of the client” (pp. 230–231). I realized my patient might have experienced trauma due to the signs she was displaying, and therefore I set out to make her feel as welcome as possible by being patient, using a calm, friendly voice, and speaking to her in Cree as much as I could.

Cultural Humility and Safety

By applying cultural humility to this clinical scenario, an important first step was to determine if I have any judgements or biases towards this patient. According to the First Nations Health Authority (FNHA, 2019), cultural humility is a life-long process that seeks to understand personal biases and to develop and maintain trustworthy, respectful partnerships.

By listening to what my patient had to say through verbal and nonverbal feedback, and respecting her opinion, I believe I was practicing cultural safety. Also, I reflected on my understanding of my culture, and how it may differ from hers. In this scenario, I displayed cultural humility by combining my prior knowledge of colonial trauma, and by reflecting on my cultural norms. By respecting her social norms, I created a friendly, welcoming environment for my patient.

Nursing Profession

In this case study situation, my reflection on cultural humility positively impacted my nursing practice. Hospitals and healthcare institutions can be feared by people who have adverse experiences from being there before, or in other European-Canadian institutions. This can apply to Indigenous Canadians, visible minorities, sexual and gender minorities, and the socioeconomically disadvantaged. There is an inherent power differential between clients and healthcare professionals in institutional environments. Cultural safety, along with humility is key to creating health equity among the entire population, by shifting complete power from the healthcare professional to now being shared by the patient and the healthcare professional. This is done by letting patients determine if their clinical encounter has been safe and by respecting their wishes (FNHA, 2019).

According to the CNA (2018), “Cultural competency should be an entry-to-practice level requirement, with ongoing professional development for all nurses” (para. 1). I believe that my undergraduate program performed an adequate job of informing us of the trauma that many Indigenous people in Canada have faced. However, I believe that the concept of cultural humility should be explored in more depth in the early years of the program, encouraging students to self-reflect on their own life experiences and connecting to the fact that their life experiences may differ greatly from their patient’s. Currently, the concept of humility is mostly explored in fourth year, mainly by this assignment. By introspection we can identify biases and judgements we may have about patients in our care. From here we can identify why we may think the way we do and use objective facts about patients and their histories to tear down judgements and stereotypes.

Based on this statement from the CNA there should be ongoing professional development specifically addressing cultural competency, humility, and safety. By practicing cultural competence and humility, it shows that the healthcare system is non-discriminatory that is welcoming to all, and therefore creating equality, and it shows the client that they are a key member of their circle of care. Cultural humility re-enforces the intrinsic worth of individuals who have been marginalized in the past due to their ethnic, cultural, or spiritual backgrounds.

Patient Outcomes

By looking beyond my patients' behaviour(s) as a seemingly resistant older lady who did not speak English very well, I was able to use my critical thinking ability to reflect on the history of Indigenous people in Canada and implement culturally safe and humble interventions. The impact that this had on my patient was that she was willing to take medications, food, water, and she allowed for my preceptor and I to reposition her to perform daily care. By practicing cultural humility, my patient also became more willing to speak to me, joke around, and we developed a therapeutic relationship.

My Future Nursing Practice

In my future nursing practice, I will continue to contemplate cultural competency, humility, and safety. Reflecting on my cultural values, and being sensitive to and asking how I can best support the cultural norms of my patients, will benefit my future patient-nurse relationships. This is true to people of other cultures. If I care for people from cultural backgrounds that I am unfamiliar with I will ensure to ask more questions and try to portray our relationship as a partnership, rather than a paternalistic relationship. I will inquire about what would make patients comfortable in different situations, especially in receiving personal care, medication, and any form of treatment, and ensure that they receive care that is culturally congruent and acceptable to them.

Recommendations

I have a few main recommendations to adequately address issues of racism towards Indigenous Canadians in healthcare. (1) in areas where there is a large population of Indigenous people, and when logistically possible, there should be a mandatory clinical placement for Nursing students in Indigenous communities. Many Indigenous communities have their own health clinics. By participating in their clinics, homecare, and possibly addictions treatment programs a nursing student can learn about the holistic nature of Indigenous healthcare and the importance of building trusting relationships. (2) I believe that the concepts of cultural humility specifically need to be explored both more in-depth, as well as early in undergraduate nursing programs. (3) During the COVID-19 pandemic, it has been difficult for nursing staff to access translators, in any language. Therefore, there should be access to translation apps that have a microphone that the patient can speak into and have it instantly translated for the healthcare professional. This could be in the form of an app on a tablet, which most units have access to for

drug libraries, or by allowing staff to use personal phones for this sole reason on the floor. Of course, the devices need to be durable enough to be disinfected after use.

Cultural competence training can lead to generalizations, even if they are positive in nature. Cultural competence training is one-dimensional and can be effective for building empathy for a specific group of people, but it does not account for intracultural variation between people. According to Jongen et al. (2018) “to avoid cultural generalizations, a more effective tactic is to learn directly from patients about their own sociocultural perspectives and how they see this impacting their encounters with healthcare professionals” (p. 11). For example, with mental health patients, I will examine their beliefs and opinions about mental health issues, as well as their spirituality. Within one ethnic group, I have observed a wide range of attitudes, such as guilt, or feelings of being “weak” for being depressed or anxious. While others have an understanding and acceptance of their current mental health status. I have also witnessed people of Indigenous descent who are very spiritually traditional, and some who practice a Christian denomination, and even some who practice a combination of both.

Conclusion

I feel that my understanding of cultural humility and cultural safety grew through this experience, as well as through writing this paper. Before this paper, I understood the concept of cultural competency quite well, as I have had lots of opportunities to learn about cultures other than my own; but I now am starting to understand and demonstrate how the concepts of cultural humility and cultural safety are also important and build on each other. This was evident in my approach in caring for an older Indigenous client who at first was fearful and resistant to treatment and care. Initially, I had to assess to rule out whether my male gender or the Cree language were also barriers in our specific healthcare relationship. The history of the trauma of both Indigenous colonization and Japanese internment in our country of Canada became the contemplated focus. By reflecting on my personal experiences in high school and being viewed as a ‘second class citizen’ by many in Canadian society, as well as my patient’s possible experiences with residential school, I was better able to support and encourage her recovery. I believe that the concepts of cultural humility specifically need to be explored both more in-depth, as well as early in undergraduate nursing programs. I also believe that in areas with a large Indigenous population, there should be mandatory clinical experiences on First Nations, by participating in their clinics, home care, and possibly addictions treatment programs. Moving forward I know that cultural competence, humility, and safety are lifelong processes that require constant assessment, reflection, and consultation with patients, as I begin my career in nursing.

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