wâhkôtowin: A nehiyaw Ethical Analysis of Anti-Indigenous Racism in Canadian Nursing

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Abstract:
Indigenous Peoples in the settler state of Canada face racism on a daily basis, including in their interactions with nurses and the healthcare system. Canadian nursing consistently fails to recognize its role in continuing to perpetrate anti-Indigenous racism. Many nurses are not adequately taught about Indigenous history, settler colonialism, and anti-racism to be able to recognize anti-Indigenous racism against Indigenous clients and families in practice, let alone effectively address it. Considering the failure of current nursing ethics to adequately recognize and take a stand against anti-Indigenous racism, I propose using the nehiyaw (Cree) concept of wâhkôtowin as an ethical perspective that can help nurses tackle this pervasive problem.

Introduction

Indigenous Peoples[1] in Canada have demonstrated incredible resilience in the face of the historic and continuing trauma they experience. While there is significant variation culturally and socially among the many Indigenous groups in Canada, the health of First Nations, Métis, and Inuit has been seriously and negatively affected by the historical and ongoing process of colonization. Indigenous peoples face disproportionly high rates of infectious and chronic disease, infant mortality, and suicide (Mikkonen & Raphael, 2010). In addition, the life expectancy for Indigenous

Peoples in Canada is significantly shorter than for non-Indigenous Peoples (Tjepkema et al., 2019). The reasons for these health disparities are complex, but they are clearly related to social inequities. For instance, the average income for Indigenous men is 58% of that of non-Indigenous men, the unemployment rate for Indigenous families is double that of non-Indigenous Peoples, and Indigenous Peoples are four times more likely to live in crowded housing conditions with food insecurity (Mikkonen & Raphael, 2010). As a graduate nursing student of mixed nehiyaw[2] (Cree) and European ancestry who has pursued higher education to better

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[1] Indigenous Peoples in Canada refers to the First Peoples of this land that include First Nations (status and non-status), Métis, and Inuit.

[2] nêhiyawêwin (Cree language) words are not capitalized according to my teachings. As Lana Whiskeyjack and Kyle Napier explain, this is done to acknowledge the fact that no

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understand these troubling disparities, it is clear to me that the systemic anti-Indigenous racism and ongoing colonization that contribute to inequitable health outcomes for Indigenous peoples are not understood by the majority of nurses. In this article, I seek to make plain the racist foundations of the nursing profession and to propose a nehiyaw (Cree) ethical perspective to challenge this racism.

Anti-Indigenous Systemic Racism

Due to the fact that racism is present in the social, economic, and political aspects of society that influence the social determinants of health, systemic racism has been proposed as a meta-social determinant of health to help explain the health inequities faced by many racialized groups (Ramaswamy & Kelly, 2015). Racism can be defined as "a *societal system* [emphasis added] in which actors are divided into 'races', with power unevenly distributed (or produced) based on these racial classifications" (Paradies, 2006, p. 145) and that creates "differential access to the goods, services, and opportunities of society" (Ramaswamy & Kelly, 2015, p. 285).

While the nature of racism is fundamentally systemic, the terms institutional, structural, and systemic racism are useful to highlight how racism is embedded in society's structures and institutions "that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups" (Paradies et al., 2008). In addition, Kwame McKenzie (2017) stresses the fact that any lack of action on the part of organizations to address racially disparate outcomes is, in fact, institutional racism. Simply put, institutional racism results in "inequitable outcomes for different racialized groups" (McKenzie, 2017, p. 5).

Perhaps the most well-known and recognized form of racism is interpersonal racism (Allan & Smylie, 2015). Also known as relational racism, interpersonal racism "refers to acts of racism that occurs between people" (Allan & Smylie, 2015, p. 5). Examples of this type of racism include being called names, being ignored, receiving poor treatment, or being the victim of various forms of violence on the basis of race (Allan & Smylie, 2015). While interpersonal racism may be the most visible form of racism, Waite and Nardi (2019) emphasize that racism cannot simply be viewed as a simple individual problem, because it is essentially a system of power. Thus, one cannot separate the interpersonal from the whole of the system as interpersonal racism is a symptom of the larger problem of structural racism (Waite & Nardi, 2019). Waite and Nardi (2019) additionally argue that while "prejudice, bias, or discrimination based on perceptions of skin color" are significant parts of racism, conceptualizing this as racism's full definition is "incomplete and misleading" (p.20). Therefore, interpersonal racism cannot be addressed in isolation of institutional racism.

As with all other institutions, healthcare is a site in which racism is present. While both Indigenous nurses and Indigenous clients experience the negative effects of racism, this analysis focuses on the issue of anti-Indigenous racism directed at clients, their families, and their communities; recognizing that that all forms of anti-Indigenous racism are interconnected. A recent inquiry into systemic discrimination against Indigenous Peoples in Quebec public services found that there is racism in the healthcare system that results in significant negative health outcomes for Indigenous clients and sometimes even death (Viens, 2019). Specifically, discrimination and racism in interactions between health care providers and patients

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word or part of a word is more important than any other.

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actively discourages Indigenous clients from seeking healthcare and negatively affects their quality of care overall (Viens, 2019). This is consistent with research that demonstrates that the health care of Indigenous Peoples in Canada is negatively impacted by "an unwelcoming environment, stereotyping and stigma, and practice informed by racism" (Wylie & McConkey, 2019, p. 37). It was found that health care providers often blame Indigenous individuals for their state of health, ignore social determinants of health, and label Indigenous clients as drug-seeking or alcoholics (Allan & Smylie, 2015; Wylie & McConkey, 2019). Negative outcomes for Indigenous people included being denied care, having their medical issues go unbelieved, having their pain go untreated or undertreated, being misunderstood, being demeaned, and having delayed service (Allan & Smylie, 2015; Wylie & McConkey, 2019).

Considering the far-reaching impacts of racism on the health of racialized peoples, it is surprising that the subject has not been investigated more in the nursing or health care ethics literature. Indeed, the Canadian Nurses Association's (CNA, 2017) *Code of Ethics for Registered Nurses* does not once mention the word racism yet speaks about the importance of the social determinants of health, social justice, and advocating for the eradication of health and social inequities. Johnstone and Kanitsaki (2009) point out that the common practice in health care of avoiding the term racism in favour of euphemisms does not stop racism and, in fact, makes it harder to address. In *The Unbearable Whiteness of Being (in Nursing)* Elayne Puzan explains how the profession of nursing has yet to challenge its whiteness, institutionalized as authority and normalness, thereby perpetuating systemic oppression. I argue that the reason the nursing profession is unwilling to address racism or even admit that it exists

is because the profession benefits from society's unequal structure and is more interested in maintaining a likable, caring image than working towards achieving equity and justice.

As an Indigenous nurse who has witnessed countless instances of racism against Indigenous people in healthcare I think it is time that nursing examined its role in perpetuating anti-Indigenous systemic racism. While nurses should be concerned with the deleterious effects of colonization and racism in all sectors of society on Indigenous health, the presence of racism in the healthcare sector and in nursing should be of the utmost concern. To address this issue and offer some potential solutions, I will analyse the issue of anti-Indigenous racism in nursing using the nehiyaw principle of wâhkôtowin[3].

wâhkôtowin

wâhkôtowin is a foundational value of nehiyaw natural law that is most often translated to English as kinship, yet the concept means more than this simple translation (Laboucan et al., 2009; Lindberg, 2020). nehiyaw epistemology is based on the "accumulated knowledge of our ancestors" (Ermine, 1995, p. 104), which is passed down through our Elders and oral traditions in the form of âcimowina (stories), âtayôhkewina (sacred stories), ceremonies, songs, culture, and language (BearPaw Media and Education [BPME], 2016; Ermine, 2007; Ermine, 1995; Shirt et al., 2012). Elders in nehiyaw communities are respected as irreplaceable sources of knowledge and "the guides of our communities" (Ermine, 1995, p. 107). As part of wâhkôtowin, the Elders teach us that everything in the universe is alive and has ahcâhk (spirit) (BPME, 2009; Campbell, 2007; Lindberg, 2020). Therefore, we are related to and interconnected with all of creation

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[3] nêhiyawêwin is an oral language, thus there are many ways to spell wâhkôtowin:

wahkotowin, wahkohtowin, wâhkôhtowin, wahkootowin.

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including our "human and other than human relatives" (Wildcat as cited in Lindberg, 2020, p. 8), such as "trees, grass and rocks" (Buhler et al., 2014, p. 185). wâhkôtowin also teaches us that all our relatives are equal: "no one is more important than the other, human, animal or the natural world, and that we are on this earth to help one another" (Buhler, 2014, p. 185). In this way, humans are interdependent with all of creation (Friedland, 2016). As part of wâhkôtowin there are obligations to conduct ourselves in proper ways that help us honour and respect our relationships (Campbell, 2007; Friedland, 2016; Lindberg, 2020). kihcheyihta (respect), love, kindness, accountability, reciprocity, equality, and responsibility are all values that help us uphold our wâhkôtowin obligations and maintain healthy relationships (BPME, 2009; Campbell, 2007; Johnson, 2017; Lindberg, 2018).

Ethical Analysis of Racism in Nursing

Although racism is widely recognized as an afront to basic ethical principles such as justice and fairness, many famous ethicists in history, such as Immanuel Kant, have defended racism and even written lengthily on the subject of racial superiority and inferiority (Kant, as cited in Allais, 2016). For nurses, the presence of racism in our practice is somewhat of a paradox, because if we accept the assumption that most nurses want to do the right thing and that they also believe that racism is wrong, then why do so many instances of racism still exist in healthcare? Racism is so deeply entrenched and normalized in Western society that it is often invisible to those perpetrating it. Invisible racism in the nursing context can manifest as making decisions for Indigenous clients that are 'for their own good' or 'to protect them' without meaningfully listening to the client, their family, and their community.

In the domains of philosophy and ethics, the question of 'why racism is wrong?' has not received as much attention as it deserves (Johnstone & Kanitsaki, 2010). However, those who have addressed the issue show that classical principles of bioethics and other principles of Western ethics do indeed demonstrate that racism is wrong. For example, Johnstone and Kanitsaki (2010) argue that racism is wrong in healthcare, because it violates the bioethical principle of 'do no harm.' They argue that the research has adequately shown that racism is detrimental to the receiving person's well-being, which results in a morally reprehensible harm to that person (Johnstone & Kanitsaki, 2010). Another relevant principle of bioethics that racism violates is that of justice (Danis et al., 2016). To uphold justice, there is "an obligation to promote health equity", because "differences in health that are avoidable, unfair, and unjust represent inequitable health" (Danis et al., 2016, p. 5). In addition, Donahue (2008) outlines many proposed reasons for why racism is wrong, including that it manifests injustice and malevolence (it makes people do bad things), and it violates the principles of equal respect, equal liberty, and equal dignity. Considering these arguments, we are again faced with the question: If racism is universally recognized as unethical, why does it continue so pervasively?

To analyse racism in the context of the relationship between Indigenous and non-Indigenous Peoples in Canada, one must consider the beginning of this relationship. We must recognize that the settler state of Canada was founded on racism. If we do not recognize the foundational nature of racism to the Canadian state, any attempt to address the issue in healthcare will be futile. In the 1400s, the Doctrine of Discovery, founded on two papal bulls of 1452 (Dum Diversas) and 1455 (Romanus Pontifex), allowed European Christians the right to land occupied by Indigenous Peoples because of what was believed to be their God-given racial superiority to those original inhabitants (Assembly of First Nations [AFN], 2018; Vowel, 2016).

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Furthermore, Europeans did not recognize Indigenous forms of land use and laid claim to the land based on the principle of Terra Nullius, which is Latin for "land that belongs to no one" (Vowel, 2016, p. 236). In this way, the Doctrine of Discovery and Terra Nullius were used to morally justify the dispossession, dehumanization, exploitation, and genocide of Indigenous Peoples in the interest of obtaining their lands (AFN, 2018).

In addition, it is important to acknowledge that settler colonialism sets not only the foundation for racism in settler states, but also frames the past, present, and future of race relations (Bonds & Inwood, 2016). Since the goal of settler colonialism is the permanent occupation of land previously occupied by Indigenous Peoples, it necessitates the eradication of Indigenous people (Bonds & Inwood, 2016). Furthermore, the racist logic of white supremacy is at the heart of settler colonialism, because it not only lowers the moral standing of Indigenous peoples, but also places whiteness at the top of the racial systems of power, allowing whiteness to dominate (Bonds & Inwood, 2016). Indeed, Bonds and Inwood (2016) explain that "white supremacy is… a rationalization for race" (p. 720). Therefore, it becomes clear that part of the reason that racism is so difficult to eradicate is because it continues to be used as an effective tool in support of white supremacy, which keeps power and privilege in the hands of those who create and continue to benefit from racist systems.

Recognising nursing's historic and ongoing vested interest in upholding white supremacy helps to explain why nursing, as a profession, is overwhelmingly complicit in racism. Owing to racism's foundational nature, any person influenced by Western culture will not be able to escape socialization into racist modes of being, including nurses (Hall & Fields, 2013; Schroeder & Diangelo, 2010). Similarly, the nursing profession must realize that its epistemological and structural roots are born of a racist dominant society (Waite & Nardi, 2019). For example, nursing originally only accepted white women into the profession and actively challenged the entry of women of colour into the fold (Waite & Nardi, 2019). To this day, white middle-class women are grossly overrepresented in nursing while minorities are underrepresented overall and occupy more often the lowest paid and less prestigious nursing positions (Schroeder & Diangelo, 2010). In nursing and beyond, it is true that "although individual whites may be 'against' racism, they still benefit from a system that privileges their group" (Schroeder & Diangelo, 2010, p. 245). Nurses have a history of using their unacknowledged white privilege to gain power, authority, and legitimacy in healthcare and thereby they "have a vested interest in upholding the status quo of existing social relations" (Hall & Fields, 2013; Hassouneh, 2006, p. 259).

While profiting from systems of white supremacy, nursing also has a tradition of hiding this fact and endeavoring to remain 'innocent' in its own eyes. In order to avoid facing complicity with racism, nursing uses several strategies that must be overcome. First of all, nursing's status as a group oppressed by gender has been weaponized to cast us solely as victims unable to perpetrate harm against others (Hall & Fields, 2013; Waite & Nardi, 2019). This type of false argument has been challenged by Audre Lorde (1984):

> What woman here is so enamored of her own oppression that she cannot see her heelprint upon another woman's face? What woman's terms of oppression have become precious and necessary to her as a ticket into the fold of the righteous, away from the cold winds of self-scrutiny? (p. 6)

As Lorde notes, having a self-image of being 'righteous' takes away the need to reflect on one's actions as one has

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permanently become good and moral. Nursing's cherished persona as the caring, ethical woman is a moral tool used to make the false claim that nurses have achieved morality and thus can legitimately act in a morally passive way because they are already 'good' (Johnstone & Kanitsaki, 2010). Nurses and other professionals have become adept at self-deception in which they can ignore that they "trade off self-interest with ethical principles" and that they "falsely believe that they have not engaged in or promoted racism or racialised practices in health care when in fact they have" (Johnstone & Kanitsaki, 2010, p. 493). Indeed, I would argue that what Martin Luther King Jr. said in 1963 about white moderates is true for white nurses in the context of anti-Indigenous racism as well:

> I have almost reached the regrettable conclusion that the Negro's great stumbling block in his stride toward freedom is… the white moderate, who is more devoted to "order" than to justice; who prefers a negative peace which is the absence of tension to a positive peace which is the presence of justice. (King, as cited in Hassouneh, 2006, pp. 259-260)

To understand why so many nurses are capable of accepting racism in exchange for an unjust social order with its uneasy façade of 'peace,' we must delve deep into the roots of Western epistemology. Seawright (2014) explains that Western settler epistemologies are founded on "racialized, anthropocentric, and capitalistic understandings" (p. 554). Within Western epistemologies exist "epistemic and moral limitations" (Seawright, 2014, p. 558) that lead to viewing the world fundamentally in a hierarchical fashion with white males at the top of the social structure. Indeed, the inherent hierarchical nature of Western epistemology made it possible for theorists like Kant and Locke to legitimize

domination as a just social order (Allais, 2016; Seawright, 2014). To avoid having to treat 'othered' humans with principles of equal respect, these theorists and settler societies simply dehumanize certain groups and accept the proposition that some classes of human are less than (Allais, 2016; Seawright, 2014). Considering the failure of classical Western philosophy to eradicate racism or indeed even denounce it, it becomes clear that a new approach is needed.

Ethical approaches such as feminist ethics and relational ethics have been created in response to criticisms about classical Western ethics and these frameworks are useful in finding new ways to approach nursing ethics (Austin et al., 2003; Liaschenko, 1993). However, considering the fact that racism also occurs on an epistemological level with the delegitimization of Indigenous ways of knowing, a step in anti-racist nursing would be to embrace Indigenous ethics regardless of the presence of non-Indigenous critical ethical traditions (Allan & Smylie, 2015). Therefore, I answer Seawright's (2014) "call for epistemic resistance" (p. 570) by using the nehiyaw concept of wâhkôtowin. As we have seen, dehumanization is a key mode of racism in Western epistemology. In contrast, the beauty of wâhkôtowin is that it teaches that everything in the universe is alive and in relationship with one another, and one must be respectful to all relations (BPME, 2009; Campbell, 2007; Lindberg, 2020). Thus, the moral loophole of dehumanization to legitimize treating others as lesser beings does not exist as there is no concept of 'lesser beings.' Additionally, when focusing on the tenets of wâhkôtowin, racism is wrong because in a relationship all entities have an obligation to treat one another reciprocally with respect (Lindberg, 2020). Elder Isaac Chamakese teaches that "we have to love each other and greet each other every day" (as cited in BPME, 2009) as part of wâhkôtowin. Remembering our interdependence and

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interconnection can help us honour and respect those with whom we share relations (Campbell, 2007; Johnson, 2017).

Working Towards the Elimination of Racism

No matter how unachievable the goal of eliminating racism may seem at times, any work towards this objective is morally necessary and worthwhile. As Schroeder and Diangelo (2010) state, "to not address racism is to actively collude with racism" (p. 245). Therefore, there are many actions nurses can take in the struggle against racism. The first step is to shine a light and reveal the racism and white supremacy hidden in plain sight in our society and institutions. Instead of relying on simple cultural notions of difference as theories that mask the underlying systemic nature of discrimination leading to health inequity, nurses need to expose racism and talk about the problem openly (Hall & Fields, 2013; Hassouneh, 2006; Puzan, 2003; Schroeder & Diangelo, 2010). If nurses do not first recognize the root of the problem, they cannot conceivably self-reflect on their motivations and learn to act in a way not influenced by racism (Hall & Fields, 2013). As long as whiteness remains invisible, it remains indestructible (Waite & Nardi, 2019).

However, while simply identifying and talking about racism is a good first step, it is not enough. Action needs to be taken to challenge it. Considering the concept of wâhkôtowin, several methods to counteract racism are relevant and supported by the literature. First, although culture is not the root problem in racial health inequities, the treatment of different ways of knowing as inferior (epistemic racism) is wrong and can be addressed in healthcare. The Truth

and Reconciliation Commission of Canada (TRC): Calls to Action outline the need to respect and allow Indigenous traditional knowledge in healthcare:

> 22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. (TRC, 2015, p. 3)

Additionally, acknowledging the importance of relationships using wâhkôtowin suggests another avenue to pursue positive relations between Indigenous and non-Indigenous Peoples: treaty relationships. While not all Indigenous peoples have signed treaties, in some areas, using Treaty principles as a guide can be helpful in navigating the complex relationship between Indigenous and non-Indigenous peoples. Oda and Rameka (2012) explain how adhering to the principles of the treaty of Te Tiriti O Waitangi (1840), such as ensuring that Māori have "all the rights and privileges of British subjects" (p. 108) and that their self-determination is respected, can lead to positive health outcomes for Māori. In the nehiyaw context, Elder Fred Campiou describes how, when the newcomers came, we, the nehiyaw people shook hands with them and agreed to live in peace and harmony. Our ancestors conducted ceremonies and lifted the pipe to honour the new relationship between our peoples. In this way, "we have a wâhkôtowin with the Moniyaw[4], a relationship" (Campiou, as cited in BPME, 2009) that comes with obligations on both sides to treat each other with respect.

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[4] White people, in nehiyawewin

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Another way that wâhkôtowin can be used to counteract racism in nursing practice is through offering a different perspective. As previously mentioned, wâhkôtowin holds all entities of creation as deserving of respect and that "no one is more important than the other, human, animal or the natural world" (Buhler et al., 2014, p. 185). Teaching this value to nurses and nursing students could have positive effects, considering that, in social psychology, the concept of the human-animal divide has been found to have serious implications for human discrimination and prejudice (Costello & Hodson, 2014). For example, it was found that having research participants read stories that likened animals to humans made the participants more compassionate towards immigrants that became 'rehumanized' through this new perspective (Costello & Hodson, 2014). While anti-Indigenous racism and other forms of racism such as anti-Black and anti-Asian racism operate and manifest in distinct ways, they are all related. Nurses have a responsibility to address all forms of racism and discrimination, and what is learned in the struggle for equity and justice for Black and Racialized Peoples can inform Indigenous anti-racist work and vice versa.

One of the ways in which racial bias escapes attention in healthcare is that it has been shown to operate on a subconscious level, making it that much more difficult to address. Implicit biases are the unconscious attitudes one holds about certain groups of people that affect one's thoughts and actions (Allan & Smylie, 2015). These biases can be positive or negative; for example, research in healthcare has shown that healthcare providers regularly demonstrate measurable pro-white implicit biases and anti-Black and anti-Latino biases (Allan & Smylie, 2015). Evidence shows that even when healthcare providers demonstrate no explicit racial biases, their unconscious biases influence clinical decision-making in ways that result in negative outcomes for their racialized

clients (Allan & Smylie, 2015; FitzGerald & Hurst, 2017; Wylie & McConkey, 2019). When healthcare professionals have implicit biases against certain groups it interferes with their ability to form a positive therapeutic relationship due to "negative emotional tone, more clinician dominance…[and] less patient-centered care" (Danis et al., 2016, p. 6). Implicit biases also negatively affect treatment recommendations; for example, racialized patients have been shown to receive less pain medication than their white counterparts (Allan & Smylie, 2015; FitzGerald & Hurst, 2017; Hall & Fields, 2013; Johnstone & Kanitsaki, 2010).

Due to the unconscious nature of implicit biases, solutions to address them are difficult to find, yet research suggests some possibilities. Many of the promising proposed solutions are in keeping with values embedded in wâhkôtowin. First of all, healthcare providers who are aware of their implicit biases have been shown to take a conscious effort to be less discriminatory in their treatment of racialized patients (Allan & Smylie, 2015). Another promising intervention is 'perspective taking.' Nurses who were asked to imagine themselves in the place of their racialized patients were shown to provide them with equal levels of pain treatment, while nurses that did not participate in the 'perspective taking' exercise gave significantly more pain medication to white patients, demonstrating their pro-white bias in action (Allan & Smylie, 2015).

Other solutions for countering provider implicit biases include focusing on communication skills training for healthcare professionals to enable them to better model positive non-verbal behaviours towards racialized patients and to better read those patients' non-verbal cues (Hagiwara et al., 2019; Levine & Ambady, 2013). Such training could include exercises such as 'counter-stereotypic imaging' which aims to change

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stereotypes by exposing healthcare professionals to stories or people that challenge commonly held stereotypes (Devine et al., 2012; Levine & Ambady, 2013). In addition, social science has shown that the ability to recognize emotions from facial expression on people from another race improves with practice (Levine & Ambady, 2013). Therefore, it is conceivable that nurses could be trained to better read and perhaps interact more authentically with racialized patients. Several more implicit bias-reducing training strategies have been proposed, including stereotype replacement (recognizing responses based on stereotypes and replacing them with unbiased responses), individuation (thinking of someone as an individual who is not defined by stereotypes of their group), and increasing opportunities for contact between groups (Devine et al., 2012). Studies on such interventions found that long-lasting reductions in the implicit biases held by participants were moderated by increased concern about discrimination in society (Devine et al., 2012). In other words, teaching people to care about injustice was the most important part of the intervention.

Another intervention that could be used to teach nurses about both the relationship between settlers and Indigenous Peoples in Canada and how to have more compassion for Indigenous Peoples would be the Kairos Blanket Exercise (Kairos Canada, 2016). As an Indigenous concept, wâhkôtowin is often learned and taught though stories in Cree culture (Shirt et al., 2012), and I would argue that it can also be taught through the modern narrative and experiential learning-based Blanket Exercise. The Blanket Exercise was developed by Kairos, a Canadian Interfaith group, to interactively teach settlers about the historical treatment of Indigenous Peoples (Baldasaro et al., 2014). In the exercise, participants imagine themselves in the place of Indigenous Peoples and start by standing on blankets spread on the floor

to represent Indigenous land prior to contact (Baldasaro et al., 2014). A script is used to show the various points in history including decimation by illnesses, Residential Schools, and the Indian Act (Baldasaro et al., 2014). The activity finishes with the participants (standing in place of Indigenous Peoples) now standing on very small sections of blankets that have been folded into tiny areas—a visual representation of how Europeans took almost all the land for themselves (Baldasaro et al., 2014). Baldasaro, Maldonado and Baltes (2014) explain that the lesson this activity teaches, with its emotional, narrative, and experiential components, is "keenly remembered" (p. 223) by participants.

Finally, while all the aforementioned strategies to combat racism and implicit bias are worthwhile, it is still crucial to remember that racism is a systemic issue and there is need for structural change to truly resolve it. Unfortunately, there is very little literature about how to effectively address anti-Indigenous systemic racism in health care (Allan & Smylie, 2015). Some promising, individual-level, clinical strategies to specifically improve Indigenous health equity, like "inequity-responsive care, culturally safe care, trauma- and violence-informed care, and contextually tailored care" (Browne et al., 2016, p. 1), require that clinicians practice in explicit consideration of the ways that systemic racism affects health. Cultural safety, in particular, is a leading concept in Indigenous health equity that was developed by Irihapeti Ramsden, a Maori nurse (Browne et al., 2016). Cultural safety emphasizes the presence of power dynamics in healthcare and encourages self-reflection about these power imbalances, learning about racism and social injustice, and empowering patients in healthcare encounters (Bailey et al., 2017; Browne et al., 2016).

Additionally, nurses who are able to recognize systemic racism, can challenge it

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through advocacy. Bailey et al. (2017) stress the importance of "place-based, multisector, equity-oriented initiatives… [and] advocating for policy reform" (p. 1459) in tackling health inequity. This could include advocating for Indigenous self-determination in healthcare, supporting Indigenous-led health initiatives, and ensuring that policies align with principles outlined in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), the Royal Commission on Aboriginal Peoples (RCAP), and the Truth and Reconciliation Commission (TRC) (Allan & Smylie, 2015). Real world examples of political advocacy for Indigenous health equity include Jordan's Principle and the #aHand2Hold campaign (Allan & Smylie, 2015; Tirmizey, 2021). These initiatives, which depend upon the leadership of Dr. Cindy Blackstock (Social Worker) and Dr. Samir Shaheen-Hussain (Physician) respectively, challenge racist policies that harm Indigenous children by using strategies that encourage care and compassion (Blackstock, 2016; Tirmizey, 2021). In this way, wâhkôtowin can be used as a guiding principle to reimagine how we practice nursing.

Conclusion

Through an exploration of the moral implications of the history and foundations of racism in nursing and society, and an analysis of racism with wâhkôtowin, we realize that anti-Indigenous racism is an issue of great ethical importance to nurses in Canada. Anti-Indigenous racism is wrong; it is unjust and harmful, it violates principles of equal dignity, and it precludes the possibility of a good relationship between Indigenous and non-Indigenous Peoples. Nurses have a moral obligation to counteract the pervasive racism in healthcare, and they can do so by taking personal steps of education and self-reflection to override implicit biases, learning to recognize and identify racism (in one's own behaviours, in others, and in

systems), speaking up when witnessing racist interactions, and advocating for systemic change to address institutional racism. Indeed, there is a need for more nursing literature, research, and action on addressing systemic racism. Finally, by embracing the Cree principle of wâhkôtowin, both to analyze the ethical problem of racism, and to provide potential solutions to address it, a new perspective in nursing ethics, which takes a stance against epistemological racism, is herein provided.

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