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## Fort William First Nation People's Perceptions of Receiving Nursing Care to Meet Their Wholistic Health Needs

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# Walden University

College of Nursing

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Kara Morriseau

has been found to be complete and satisfactory in all respects,  
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Walden University  
2026

Abstract

Fort William First Nation People's Perceptions of Receiving Nursing Care to Meet Their  
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Kara Morriseau

MN, Athabasca University, 2020

BScN, Lakehead University, 2012

Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy  
Nursing

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## Abstract

There was limited knowledge of First Nations people's experiences receiving nursing care to meet their wholistic health needs in Northern Ontario. The purpose of this qualitative interpretive description study, grounded in the two-eyed seeing framework and the Indigenous wholistic theory, was to explore First Nations people's descriptions of receiving nursing care to meet their wholistic health needs in Northern Ontario. The study took place in the community of Fort William First Nation, a First Nations community in Northern Ontario. With approval from the Chief and Council of Fort William First Nation, semistructured interviews were conducted in person and on Zoom with Fort William First Nation participants alongside a local community knowledge holder. Data were analyzed using manual hands-on coding and thematic analysis. Three themes emerged: negative nursing experiences resulting in unmet needs, nursing practice and nursing education needing change, and a need to honor and integrate First Nation beliefs. Addressing racism, discrimination, and prejudice in nursing practice and nursing education is an urgent priority to promote positive social change. Future research that honors and integrates cultural beliefs and traditions into nursing care and nursing education may improve health outcomes and ensure nursing graduates can deliver culturally appropriate care to First Nation people's that is free from racism and discrimination and honors their cultural beliefs.

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## Dedication

This dissertation is dedicated to the participants of Fort William First Nation and Chief and Council leadership. Chi-Miigwetch for trusting me and allowing me the opportunity to hear your stories and share your stories of receiving nursing care to meet your wholistic health needs. I am hopeful your stories you shared can make positive social change in nursing practice and nursing education so that our people can receive culturally appropriate nursing care that honors our wholistic health needs, cultural beliefs, and traditional practices.

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Thank you, Dr. Kaur, for the continued support as my chair and mentor. Your support, knowledge, and experience in the dissertation process were invaluable. You challenged me, encouraged me, reminded me to take breaks, and celebrated with me along the way. Thank you, Dr. Diener, for the continued support as my committee member and mentor. You always encouraged me to keep my population of focus of Indigenous peoples' with warm embrace. You constantly supported the integration of Indigenous worldview and methodologies in the dissertation process while navigating the requirements of the Western research process.

To my knowledge holder of Fort William First Nation, Margie Bannon, your excitement, compassion, knowledge, and support for the participants and myself throughout this entire dissertation process has been crucial to completing this study. The stories of Fort William First Nation participants could not have been shared without you.

Thank you, Dr. Damien Lee for providing guidance on how to ensure Indigenous research methodologies are honored, preserved, and protected while navigating a western methodology requirement of this dissertation.

Finally, to my parents, fiancé, daughter, brother, and close friends, your countless hours, days, weeks, months, and years of support through my entire PhD process did not go unrecognized. You each picked up parts of the slack of our lives and understood my absence while I had to focus on my studies. Each of you acted as my biggest encouragers and supporters in your own way. I know this would not have been possible without you all. I am looking forward to a much slower pace in our lives for the near future.

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## Chapter 1: Introduction to the Study

Western holistic health, with an “h,” has been documented as focusing on the whole of something, not the individual parts. This focus on the sum of the whole has been seen as superior to the individual parts (Miles et al., 2023). Similarly, Western medical care focuses on the disease’s anatomical, physiological, and scientific aspects (Asamoah et al., 2023; Eni et al., 2021). These approaches do not meet the wholistic health needs of Indigenous peoples’, resulting in barriers, discrimination, and inequities contributing to unmet health needs, limited health care access, racism, prejudice, and lack of culturally appropriate health care (Josewski et al., 2023; Kitching et al., 2020; Matheson et al., 2022; Wu et al., 2023). In 2021, 1.8 million or 5% of Canadians identified as Indigenous (Government of Canada, n.d.-a). Indigenous patients attest that there is a heavy focus on the Western biomedical model treating only the physical ailments of health, resulting in a lack of integration of Indigenous cultural beliefs and knowledge into care delivery (Asamoah et al., 2023; Eni et al., 2021; Pilarinos et al., 2023; Tremblay et al., 2020).

Wholistic health, with a “w” for Indigenous peoples’, acknowledges and honors Indigenous peoples’ ways of knowing and being through the tenets of wholeness and wholism (Miles et al., 2023). Indigenous peoples’ wholistic health beliefs have been well defined in the literature as a balance and interconnectedness of the four directions of east, west, north, and south and the four domains of physical, emotional, mental, and spiritual health (Absolon, 2010; Barnabe, 2021; Vervoort et al., 2022). Multiple researchers have explored Indigenous peoples’ experiences of receiving health care from Western health care delivery models and Indigenous-led health care delivery models for different

domains of health. Indigenous participants explained that it is not possible to treat only one domain of health, such as a chronic disease in the physical domain, but care must encompass the interconnectedness of all dimensions (Burnett et al., 2020; Cassidy-Matthews et al., 2024; Gould et al., 2021; Ryan et al., 2020). Indigenous beliefs support the belief that no one domain of health is superior to the other, and each domain is equal, interconnected, and interdependent (Absolon, 2010; Chai, 2024; Gould et al., 2021; Kyoon Achan et al., 2022; Ryan et al., 2020).

It is crucial to acknowledge the impact colonialism has had on Indigenous peoples' wholistic health and to integrate Indigenous wholistic health beliefs, Indigenous knowledge, traditional healing, culture, and interconnectedness to caring for all domains of health (Gall et al., 2021; Kennedy et al., 2022; Kyoon Achan et al., 2022; Matheson et al., 2022; Waddell et al., 2021). In Canada, Indigenous peoples' are composed of First Nation, Metis, and Inuit people, each with a unique history in Canada, cultural practices, and beliefs (Aistle et al., 2024; Government of Canada, n.d.-a). Through colonialism, at the hand of the Government of Canada, Indigenous peoples' faced assimilation to Western cultural views through Residential Schools, the Sixties Scoop, the Indian Act, and Treaties (Eni et al., 2021; Goodman et al., 2017; Sasakamoose et al., 2017). Indigenous peoples' still feel the impacts of colonialism and assimilation and will for future generations to come (Goodman et al., 2017; Philpott, 2018; Smallwood et al., 2020; Turpel-Lafond, 2020).

Historical records and current data identified Indigenous peoples' as having an extremely high prevalence of chronic disease, mortality, health inequities, and poorer

health outcomes compared to non-Indigenous peoples' (Kyoon Achan et al., 2022; Matheson et al., 2022; Wylie et al., 2019). This places a substantial burden on Indigenous peoples', Indigenous communities, governments, health care resources, and health care providers. The connection between Indigenous peoples' and Indigenous history, including the effects of colonization, continues to influence Indigenous health, contributing to current health conditions, health inequities, and the prevalence of chronic diseases (McLane et al., 2020; Vigneault et al., 2021; Yangzom et al., 2023). Many researchers called upon strength-based approaches to honor Indigenous ways of knowing and being to improve Indigenous people's wholistic health (Cassidy-Matthews et al., 2024; Kennedy et al., 2022; Kyoon Achan et al., 2022). There is an urgent need to move toward understanding Indigenous peoples' wholistic health needs alongside Western health care delivery and to develop appropriate cultural care delivery that can improve outcomes for Indigenous peoples' (Eni et al., 2021; Morriseau & Fowler, 2023; Pilarinos et al., 2023).

The Truth and Reconciliation Commission of Canada's (2015) Calls to Action, and the United Nations Declaration on the Rights of Indigenous peoples' (UNDRIP) (2007), acknowledged the history of colonization by the Canadian government and its ongoing impact on the culture, health, and wellbeing of Indigenous peoples', both historically and in the present. The Truth and Reconciliation Commission of Canada called upon the government to address the current state of Indigenous peoples' and their health care rights, to value Indigenous healing practices, to ensure health care professionals in practice receive cultural competency training, and to ensure medical and

nursing schools' delivery of an Indigenous health course. The UNDRIP outlined that Indigenous peoples' have the right to self-determination, the right to a high standard of health, the right to their traditional medicines, and the right to maintain cultural health practices (Redvers & Blondin, 2020; Turpel-Lafond, 2020).

Federal and provincial nursing education accreditation and nursing practice regulations have mandated integrating The Truth and Reconciliation Commission of Canada's (2015) Calls to Action into education and practice (Canadian Association Schools of Nursing, 2023, 2025; Canadian Nurses Association, 2017; College of Nurses of Ontario, 2019). Nursing faculty are required to integrate Indigenous health content into curricula to meet the mandate and accreditation standards (Canadian Association Schools of Nursing, 2025; Canadian Nurses Association, 2017; College of Nurses of Ontario, 2019; The Truth and Reconciliation Commission of Canada, 2015). However, nursing faculty reported a lack of knowledge in understanding Indigenous peoples' health needs to integrate into curricula in response to accreditation standards (Doria et al., 2021; Hantke et al., 2022; Vass & Adams, 2021). Also, nurses in practice reported a lack of knowledge of Indigenous peoples' history, cultural needs, and caring for Indigenous peoples' (Barbo & Alam, 2024; Horrill et al., 2022; Leclerc et al., 2020).

Exploring Indigenous participants' experiences of receiving nursing care to meet their wholistic health needs can be a tipping point to produce a connection between Indigenous peoples' and the biomedical world of the health care system to improve their health outcomes and reduce disparities (Mitchell et al., 2022; Nader et al., 2017). Results from the current study may inform future research exploring targeted nursing

interventions and improvements in clinical safety and quality of care while honoring Indigenous ways of knowing and beliefs and contributing to positive social change (see Cassidy-Matthews et al., 2024; Jamieson Gilmore et al., 2023; Pilarinos et al., 2023). This chapter includes the background, problem statement, purpose of the study, and research question. The theoretical and conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, and significance of the study are also presented.

### **Background**

Indigenous peoples' are the fastest growing population, growing by 9.4% between 2016 and 2021 (Government of Canada, n.d.-a). Indigenous peoples' have unique differences in colonialism and their history, which sets them aside from other racial minority populations, thereby increasing the importance of Indigenous health understanding (Leclerc et al., 2020; Nader et al., 2017). The history and present impact of colonialism has resulted in it being referenced as a social determinant of health for Indigenous peoples', affecting their wholistic health (Blanchet Garneau et al., 2021; Cooper et al., 2021; Wylie et al., 2019).

Residential Schools, the Sixties Scoop, and the Indian Act enforced by the government have negatively affected the wholistic wellbeing of Indigenous peoples' historically and presently. The Residential School legacy continues to foster health inequities for Indigenous peoples' (Gould et al., 2021; Josewski et al., 2023; Kyoon Achan et al., 2022; Matheson et al., 2022; McVicar et al., 2021). The Sixties Scoop has left many Indigenous children to be raised by non-Indigenous peoples' and to remain

separated from their cultural identity (Matheson et al., 2022). Presently, Indigenous children continue to account for over half of children under 14 in foster care (Matheson et al., 2022). The Indian Act outlines who is eligible to be a status Indian, which determines the benefits and resources status to which Indians are entitled. Health care delivery for status Indian members only on reserves under the Indian Act is the responsibility of the federal government (Astle et al., 2024). The Indian Act excludes those who are not eligible for status, thereby denying them the right to access health benefits on reserve. There remains a prominent inequity in access to health care for Indigenous peoples' due to federal jurisdictional dollar allocation and those who do not meet the criteria to be a status Indian (Harasemiw et al., 2018; Matheson et al., 2022; Wylie et al., 2019). The Indian Act historically and presently enforces systemic racism and epistemic racism onto Indigenous peoples' (Matthews, 2017).

Despite the growing Indigenous population in Canada, the prevalence of long standing health disparities for Indigenous peoples' remains elevated compared to non-Indigenous peoples' (Hahmann & Kumar, 2022; Yangzom et al., 2023). The prevalence of diabetes, arthritis, asthma, obesity, respiratory disease, and mental illness remains higher for Indigenous peoples' in Canada than for non-Indigenous peoples' (Chang et al., 2024; Loyola-Sanchez et al., 2020, Public Health Agency of Canada, 2018). The health status of Indigenous peoples' in Canada is well below the Canadian average with a shorter life expectancy (Pilarinos et al., 2023; Vigneault et al., 2021).

The Truth and Reconciliation Commission of Canada (2015) Calls to Action called upon health care institutions, nursing schools, and medical schools to deliver

Indigenous health content and ensure all health care providers are trained to provide culturally competent care to Indigenous peoples'. In response to the Calls to Action, Nursing accreditation bodies of the College of Nurses of Ontario and the Canadian Nurses Association of Canada have mandated the integration of the Truth and Reconciliation Commission of Canada Calls to Action into nursing curriculums (Canadian Association Schools of Nursing, 2025; Canadian Nurses Association of Canada, 2017; College of Nurses of Ontario, 2019). College of Nurses of Ontario (2023) published a new Code of Conduct, which identified that nurses must maintain continuous education on key topics of Indigenous health care, antiracism, cultural safety, and cultural humility. Canadian Nurses Association (2017) Code of Ethics identified that nurses in practice, nursing educators, and nursing students must adhere to the Truth and Reconciliation Commission of Canada's (2015) Call to Action and acknowledge and respect Indigenous history and Indigenous peoples' interests. Canadian Association Schools of Nursing (2025) released cultural humility and cultural safety standards for nursing education.

Despite these mandates for accreditation and education requirements in Canada, the literature identified that Indigenous peoples' receive inadequate Western health care with an overreliance on the Western biomedical model; experience racism, discrimination, and prejudice; and experience barriers to adequate care including lack of access, lack of communication, lack of knowledge of Indigenous culture, lack of ways of knowing and being (Cooper et al., 2021; Josewski et al., 2023; Turpel-Lafond, 2020; Wu et al., 2023). Indigenous patients highlighted that their experiences receiving Indigenous-

focused health care or Indigenous-led health care resulted in positive experiences that integrated and honored Indigenous health beliefs (Kyoon Achan et al., 2022; Pilarinos et al., 2023; Wu et al., 2023).

Nurses deliver care in remote Indigenous and urban communities through Western-led and Indigenous-led health care delivery models. The nursing experiences of Indigenous patients, their high chronic disease prevalence, and their health inequities are closely related to nurses in practice and nursing education delivered by nursing faculty. Indigenous patients reported receiving care that results in unmet health needs, racism, discrimination, poor health care experiences, and a lack of culturally appropriate care honoring Indigenous health beliefs (Browne et al., 2022; Cassidy-Matthews et al., 2024; Kitching et al., 2020; Loyola-Sanchez et al., 2020; Pilarinos et al., 2023). Despite requirements to respond to accreditation and government mandates, Nursing educators are not prepared to deliver a curriculum to respond, leaving nursing graduates unprepared to deliver culturally appropriate care to Indigenous peoples'. Nursing educators lack knowledge and understanding of Indigenous health and sometimes exhibit White privilege, colonization, and racism in their teaching pedagogy, reinforcing colonial curricula (Francis-Cracknell et al., 2022; Hantke et al., 2022; Van Bower et al., 2020). Nurses delivering care to Indigenous peoples' in practice reported a lack of knowledge of Indigenous peoples' culture, history, and health needs to integrate into care delivery (Berg et al., 2019; Leclerc et al., 2020; Wylie et al., 2021; Yaphe et al., 2019).

Indigenous participants have shared their experiences living with many chronic diseases and health conditions impacting their different domains of health. When

describing their experiences, Indigenous peoples' have recounted that the disease or health condition impacts more than the physical ailment of health. Emotional, mental, and spiritual domains of health have been identified as interconnected to physical health being impacted by chronic diseases or other health conditions (Cassidy-Matthews et al., 2024; Gall et al., 2021; Kyoon Achan et al., 2022; Vervoort et al., 2022). Spirituality, cultural practices, and cultural beliefs are relational to all domains of health and Indigenous peoples' wholistic health needs (Abolson, 2010; Burnett et al., 2022; Kyoon Achan et al., 2022; Matheson et al., 2022). Despite these clear indicators of wholistic health needs by Indigenous peoples', the descriptions of First Nation peoples' experiences in receiving nursing care to meet their wholistic health needs were absent in the literature. The current study addressed the need to explore the experiences of First Nation people's in Northern Ontario regarding their reception of nursing care to meet their wholistic health needs. Findings may be used to improve nursing education and nursing practice and to improve the health status of Indigenous peoples', their health inequities, and the overreliance on the Western biomedical model.

### **Problem Statement**

There is limited knowledge of what First Nations people's in Northern Ontario experiences are in receiving nursing care to meet their wholistic health needs. Indigenous peoples' report racism, prejudice, discrimination, barriers to adequate care, health care inequities, a projection of the Western biomedical model of care, and a lack of integration of Indigenous health beliefs when accessing health care (Barbo & Alam, 2024; Nguyen et al., 2020; Phillips-Beck et al., 2020; Sehgal et al., 2023). There is an urgent need to

increase culturally safe and culturally appropriate care provided to Indigenous patients to address the high prevalence of chronic disease, mortality, health inequities, poorer health outcomes, and unmet health needs (Barbo & Alam, 2024; Kitching et al., 2020; McLane et al., 2020; Phillips-Beck et al., 2020; Wylie et al., 2021).

Integrating Indigenous knowledge, traditional practices, health beliefs, and wholistic health into nursing care and nursing education can result in Indigenous peoples' receiving culturally safe and culturally appropriate care (Allen et al., 2020; Pilarinos et al., 2023; Tremblay et al., 2020). For example, Phillips-Beck et al. (2020) noted participants suggested integrating traditional medicines, advocates, and translators into care of First Nations people's can improve First Nations people's care received in the health care system. Pilarinos et al. (2023) explained Indigenous participants advocated that integrating Indigenous traditional health, culture, traditional medicines, ceremony, and access to Indigenous elders into health care delivery can improve Indigenous patients' wellbeing. Many Indigenous patients advocate that cultural safety education and education on colonialism must be mandatory for all health care providers to improve cultural safe delivery of care (Cassidy-Matthews et al., 2024; Phillips-Beck et al., 2020; Pilarinos et al., 2023).

Nursing educators and nurses in practice identify knowledge deficits in understanding Indigenous peoples' wholistic health needs, healing practices, culture, and history, further widening the gap in Indigenous peoples' receiving adequate care. Nursing faculty report a lack of knowledge in understanding Indigenous' peoples' health needs to integrate into curricula in response to the Truth and Reconciliation Commission of

Canada Calls to Action, nursing education accreditation standards, and nursing practice regulation requirements (Doria et al., 2021; Hantke et al., 2022; Vass & Adams, 2021).

Nurses in practice report a lack of knowledge of Indigenous peoples' and caring for Indigenous peoples' (Barbo & Alam, 2024; Horrill et al., 2022; Leclerc et al., 2020).

Integrating Indigenous knowledge and traditions into nursing curricula and nursing interventions to care for the interconnectedness of the physical, mental, spiritual, and emotional aspects of Indigenous peoples' health alongside biomedical interventions can improve Indigenous adults' overall health and wellbeing (Ahmed et al., 2021). There is an opportunity to move beyond the Western biomedical care delivery model and honor Indigenous knowledge, ways of knowing, and cultural beliefs (Eni et al., 2022; Kennedy et al., 2022; Philips Beck et al., 2020). It is imperative to prioritize Indigenous voices, knowledge, traditions, and practices to develop culturally appropriate interventions to transform Indigenous health outcomes and address Indigenous health disparities (Jull et al., 2023; Oosman et al., 2021; Wu et al., 2023).

The research problem is that it is not known what First Nation people's in Northern Ontario experience in receiving nursing care to meet their wholistic health needs. Understanding Indigenous peoples' history, culture, and health care experiences can support nurses in practice and nursing educators in understanding Indigenous peoples' health and wellness needs to foster culturally appropriate care of Indigenous peoples' wholistic health needs (Blanchet Garneau et al., 2021; Burnside et al., 2023; Emanuelson et al., 2023; Eni et al., 2021; Gould et al., 2021; Phillips-Beck et al., 2020). Through understanding Indigenous wholistic health needs, culturally safe and culturally

appropriate nursing care can be provided to Indigenous peoples' (Kennedy et al., 2022; McGough et al., 2022; Wiley et al., 2021). First Nations people's in Northern Ontario, through this qualitative study, can describe their experiences in receiving nursing care to meet their wholistic health needs to support curriculum development and nursing practice training programs, and offer insights into their unique wholistic health needs to support future research.

### **Purpose of the Study**

It is not known what First Nations people's in Northern Ontario experiences are in receiving nursing care in Canada to meet their wholistic health needs. This study implemented a qualitative interpretive description design to describe First Nations people's experiences when receiving nursing care to meet their wholistic health needs. The Indigenous wholistic theory (Abolson, 2010) and the two-eyed seeing framework (Bartlett et al., 2012; Rieger et al., 2020; Roher et al., 2021) guided this study.

### **Research Question**

The study aimed to answer the research question of what are the experiences of First Nations people's in Northern Ontario when receiving nursing care to meet their wholistic health needs?

### **Theoretical and/or Conceptual Framework for the Study**

The research study is grounded in the theoretical foundation of the Indigenous wholistic theory (Absolon, 2010) and the conceptual framework of the two-eyed seeing/etuaptmunk framework (Bartlett et al., 2012; Rieger et al., 2020; Roher et al.,

2021). Both the Indigenous wholistic theory and the two-eyed Seeing/etuaptmumk framework are interconnected and were integrated throughout the study.

The Indigenous wholistic theory is rooted in Indigenous knowledge and health beliefs, supporting the key phenomenon of Indigenous wholistic health. Abolson (2010) identifies that Indigenous wholism integrates concepts of the circle of life, connectedness between self, family, community, and environment, relationships, balance, interrelatedness, interconnectedness, and fosters growth, balance, and relevance. The Indigenous wholistic theory explains that there is a whole cyclical, ecological, and relational being of Indigenous peoples' that includes historical, social, political, and economic factors impacting an Indigenous person's sense of peace, balance, and harmony in life, which are explained through the four directions (Abolson, 2010). All four navigational directions and each sub concept of health are interconnected, with the center of the four directions representing the fire of life and oneself (Absolon, 2010). The Indigenous wholistic theory identifies the four major concepts of each direction: east, west, south, and north with supporting domains of physical, emotional, spiritual, and mental wellbeing (Absolon, 2010).

The Indigenous wholistic theory is used to guide this study. It addresses the current research problem that First Nation people's in Northern Ontario's descriptions of receiving nursing care to meet their wholistic health needs are absent in the literature. It can guide the interview process so that First Nation participants can describe their wholistic health needs regarding the interconnectedness of four major concepts of east, west, south, and north, and their sub concepts of physical, emotional, spiritual, and

mental wellbeing. The limitation of this theory is that it cannot be used for non-Indigenous peoples' health, but it is a strength for this research proposal as the focus is on First Nation people's. The theory is very distinct in incorporating Indigenous ways of knowing, being, and health. The theory can be used to support interviewing, data collection, data analysis, and conclusions of the study.

The two-eyed seeing framework is a gift as it allows individuals to “learn to see from one eye with the strengths of Indigenous knowledge and ways of knowing, and from the other eye with the strengths of Western knowledge and ways of knowing, and to using both these eyes together, for the benefit of all” (Bartlett et al., 2012, p. 335). The two-eyed seeing framework allows individuals to weave back and forth between knowledge to understand Indigenous knowledge and Western knowledge to see the bigger picture. The two-eyed seeing framework embodies the understanding that Indigenous knowledge is a whole system that is not static and historical, but it belongs in the present and has meaning for family, community, and Indigenous peoples' (Bartlett et al., 2012).

The two-eyed seeing framework is used to guide all aspects from start to finish of the study, including the literature review, methodology, interview guide, data collection, data analysis, and conclusions. As the researcher, I have both of First Nation and settler heritage. I am both a nurse and nursing educator as well as a First Nation patient who accesses health care. The identity of myself as an individual and a professional is the crux of the two-eyed seeing approach.

The two-eyed seeing framework allows for a “complete picture of a person, their spirit, their physical being, their emotions, their intellectual being...all have to be fact to and work in a very harmonious way” (Bartlett et al., 2012, p. 336). Using the two-eyed seeing framework, Indigenous wholistic health beliefs can be analyzed alongside Western holistic health beliefs for a complete picture of Indigenous peoples’ experiences. The two-eyed seeing framework allowed for First Nations participants’ knowledge and experiences to be captured and aligned with the Indigenous wholistic theory and Western holistic health through interviewing, follow up questions, and data analysis.

### **Nature of the Study**

To address the research questions in this qualitative study, the specific research design is interpretive description design (ID). Interpretive description design is a type of basic qualitative research that is not a formal method with a prescriptive or circumscribed sequence of steps (Thorne, 2016). ID allows for the ability to integrate all available design approaches to understand all patterns of human experience to guide future decisions (Thorne, 2016). ID design does not prescribe data analysis techniques. Thorne (2016) articulated that regardless of the data analysis approach chosen, researchers must be engulfed in their data and know their data (Thorne, 2016). This study employed data analysis using a constant comparative analysis approach. Constant comparative analysis is an analytical approach that stems from grounded theory and is often used in ID, focusing on commonalities and patterns of subjective human experiences (Adams et al., 2021; Thompson Burdine et al., 2021; Thorne, 2016). Adams et al. (2021) used constant

comparative data analysis to explore access to ultrasound imaging for Indigenous communities in two northern remote communities in Canada.

Interpretive description's goal is to understand a complex phenomenon by capturing the knowledge of those impacted by the phenomenon. Cassidy-Matthews et al. (2024) used interpretive description (ID) with thematic analysis to describe Indigenous participants' experiences with and perspectives on liver transplantation. Wright et al. (2019) applied the two-eyed seeing framework in an interpretive description design study with thematic analysis to explore Indigenous mothers' experiences of primary health care for their infants. ID is action orientated with a focus on practical implications and patient outcomes (Cassidy-Matthews et al., 2024; Jackson et al., 2022; Ocean et al., 2022; Thompson Burdine et al., 2020; Wright et al., 2019). Exploring First Nation people's experiences of receiving nursing care to meet their wholistic health needs through an ID approach allowed for Indigenous knowledge to be shared, practical implications for nursing education and nursing practice to be identified, and Indigenous patient outcomes to be improved.

### **Definitions**

*Canadian Association Schools of Nursing (CASN)*: An accrediting agency for university and college nursing programs and advocates for nursing education and research at a federal level for baccalaureate and graduate nursing programs (Canadian Association Schools of Nursing, n.d.).

*Canadian Nurses Association:* A federal body that advocates for nursing across all 13 provinces and territories and national level for Canadian nursing (Canadian Nurses Association, n.d.).

*College of Nurses of Ontario (CNO):* The provincial body in Ontario that regulates, authorizes, and approves nursing programs in Ontario (College of Nurses of Ontario, n.d.). The CNO manages, maintains, and adheres to the regulations of registered practical nurses, registered nurses, and nurse practitioners in Ontario (College of Nurses of Ontario, n.d.).

*Colonization/colonialism:* The action of invading lands and enforcing legislation or policies to take control of an area or group of people. Indigenous peoples' experienced the loss of cultural identity, cultural traditions and knowledge, land, and connection to the land through the Indian Act, Treaties, Residential Schools, and the Sixties Scoop (Matheson et al., 2022).

*First Nation:* First Nation people's are the original inhabitants of Canada pre-European contact and include those who are status Indians, non-status Indians, and treaty Indians (Astle et al., 2024). Status Indians are outlined under the Indian Act whereas non-status Indians are not eligible to be status Indians under the Indian Act, but they belong to a First Nation nonetheless (Astle et al., 2024). Treaty Indians belong to a First Nation that has a treaty with the crown (Astle et al., 2024).

*Holistic health:* A Western belief of holism that originated from Florence Nightingale to care for the whole person (mind, body, spirit), integrating empathy, compassion, and equality (Morriseau & Fowler, 2023; Van Bower et al., 2020).

*Indian Act:* A federal Canadian law that outlines bands, reserves, Indian status, and federal resource allocation for First Nations people's (Government of Canada, n.d.-d). First Nation people's human rights were removed, and they were forced to assimilate into the Indian Act (Castellano et al., 2008; Vigneault et al., 2021). The allocation of resources through the Indian Act remains under federal jurisdiction, including health care (Matheson et al., 2022).

*Indigenous:* Indigenous peoples' are comprised of First Nation, Metis, and Inuit people (Government of Canada, n.d.-a).

*Inuit:* Inuit people are the largest non-crown land comprised of four separate regions of Inuvialuit, Nunavik, Nunatsiavut, and Nunavut making up 35% of Canada's land mass with about 70,545 people identifying as Inuit (Government of Canada, n.d.-c).

*Metis:* Metis people currently make up 585,110 people in Canada (Government of Canada, n.d.-b). "Métis means a person who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation" (Canadian Geographic Indigenous peoples' Atlas of Canada, 2024).

*Residential Schools:* Indigenous church schools and institutions were established in the 1830s with the last one closing in 1996 in Canada. The goal of Residential Schools was to take the Indian out of the child (Sinclair, 2007). Residential Schools did this by inhibiting the ability of Indigenous children to practice Indigenous cultures or languages, denying their Indigenous beliefs or ways of being, and punishing Indigenous children with physical abuse, emotional abuse, sexual abuse, and neglect (Astle et al., 2024; Matheson et al., 2022; Sinclair, 2007; Vigneault et al., 2021).

*Sixties Scoop:* From the 1950s to the 1990s, numerous Indigenous children were apprehended from their families and communities without the consent of the families or bands throughout Canada by the Canadian government (Benoit et al., 2019; Matheson et al., 2022). The Sixties Scoop resulted in roughly 70% of these children being apprehended at birth and adopted by non-Indigenous families (Sinclair, 2007). The government and child welfare agencies had little regard for preserving the cultural identity of these children (Matheson et al., 2022; The Truth and Reconciliation Commission of Canada, 2015).

*Truth and Reconciliation Commission of Canada:* The Truth and Reconciliation Commission of Canada was established from the Indian Residential Schools Settlement Agreement. Its purpose was to explore and examine the truth of what happened in Residential Schools and facilitate reconciliation through developing calls to action for the government and Canadians to reconcile with Indigenous peoples' in Canada (Government of Canada, n.d.-e; The Truth and Reconciliation Commission of Canada, 2015).

*United Nations Declaration on the Rights of Indigenous peoples' (UNDRIP):* A United Nations declaration internationally focusing on acknowledging, recognizing, and respecting Indigenous peoples' human rights (Government of Canada, n.d.-f). The UNDRIP was formally accepted as an Act in Canada in 2021 as the UN Declaration on the Rights of Indigenous peoples' Act (Government of Canada, 2023).

*Wholistic health:* Wholistic health is different than Western holistic health beliefs (Miles et al., 2023; Van Bower et al., 2020). Indigenous peoples' cultural belief that

health involves a balance and interconnectedness between physical, emotional, mental, and spiritual domains inclusive of historical, social, political, and economic factors impacting Indigenous peoples' (Abolson, 2010; Batal et al., 2021; Gall et al., 2021; Moscou, 2022; Vervoort et al., 2022).

### **Assumptions**

The study has four major assumptions. The first assumption is based on the constructivist ontology that there is not one truth but multiple truths that are subjective through individual interactions (Burkholder et al., 2020). There are meanings to all things in the world, and meanings are different for all people as human beings have complex and subjective lived experiences (Erikson, 2011; Ravitch & Carl, 2021). Indigenous peoples' (First Nation, Metis, and Inuit) have different cultural beliefs, languages, and ways of being. Despite these cultural differences, using the Indigenous meanings of wholistic health in the Indigenous wholistic theory allows First Nations participants to share how their cultural beliefs, languages, and ways of being may be slightly different depending on their community of belonging. This assumption aligns with the interpretive constructivist approach that people learn through experiencing the world around them, interpreting what they encounter, exploring how they individually assign meaning and values and (Rubin & Rubin, 2012). This assumption also aligns with Indigenous research methodologies that knowledge is wholistic and cyclical, with many truths or stories existing depending on the individuals' personal experiences (Kovach, 2021; Simpson, 2000; Wilson, 2008)

The second assumption is that due to the colonial history Indigenous peoples' have had to endure, First Nation participants may have experienced cultural identity, cultural practices, and cultural loss (Matheson et al., 2022). Some participants might not be able to speak to or address all aspects of their wholistic health needs like other participants. The third assumption is that Indigenous peoples' may be hesitant to participate in this research study given the history of unethical research and distrust in health care providers (Bull et al., 2022; Matheson et al., 2022). The fourth assumption is based on the epistemological and axiological assumption that as the researcher, I am both an Indigenous person and a settler, a nurse and a patient, and a nursing educator and a student researcher. My multiple identities integrate into the phenomenon of interest. I am also an apprentice in a quest for learning and seeking knowledge from elders and First Nations people's (Simpson, 2000). I am an insider in this research process (Kovach, 2021).

### **Scope and Delimitations**

This qualitative interpretive description study aims to explore the experiences of First Nations people's in Northern Ontario when receiving nursing care to meet their wholistic health needs. It is not known what First Nation people's experiences are when receiving nursing care to meet their wholistic health needs. This focus was chosen as the literature demonstrates research has explored Indigenous peoples' as a group not specifically First Nations people's or the geographical area of Northern Ontario. The literature further explored the general experiences of health care and certain aspects of their health, like physical or mental, but not their wholistic health needs. As nursing

practice and nursing education are interwoven through federal and provincial accreditation and regulation, results from the study can aid in supporting nursing practice and nursing education changes to integrate Indigenous peoples' wholistic health needs into curricula and training programs for nurses.

First Nation people's in this study can have diverse identities, living locations, or different health care environments for receiving nursing care. First Nations participants can receive nursing care in hospitals, rehabilitation, outpatient clinics, and primary care health clinics in urban cities or rural Indigenous communities. First Nations people's must self-identify as First Nations, either being status, non-status, or treaty members. Indigenous participants can live in urban, rural, and semi rural areas or a First Nations community. Due to these differences, the wholistic health needs of First Nations people's may vary geographically across Canada. This study focuses on Fort William First Nation people's in Northern Ontario community and thus cannot be projected onto Inuit, Metis or other First Nations communities. There is a need to collaborate with local Indigenous peoples' when determining their care needs (Canadian Association Schools of Nursing, 2025; Kennedy et al., 2022; Phillips Beck et al., 2020). Despite these differences, a similar study can be conducted in different geographical regions to understand different Indigenous perspectives of other First Nations, Metis, or Inuit people globally.

Western theories were not investigated as they do not align with Indigenous peoples' ways of being and have been projected onto Indigenous peoples' throughout history and presently (Bruton et al., 2021; Matheson et al., 2022; Morriseau & Fowler, 2023; Van Bewer et al., 2020). The Indigenous wholistic theory and two-eyed seeing

framework were chosen as they align with Indigenous knowledge, ways of being, health beliefs, and the research question. Indigenous theories and frameworks related to the study but were not investigated are Indigenous institutional theory, Indigenous Standpoint Theory, and the medicine wheel.

### **Limitations**

The qualitative interpretive description design approach aims to describe First Nations people's experiences when receiving nursing care to meet their wholistic health needs. This study's three limitations are related to sampling techniques, diversity of the sample, and interview techniques.

The study deployed purposeful sampling and snowball sampling concurrently in Fort William First Nation. Purposeful sampling allows the researcher to select participants that can respond to the research question (Singh & Thirsk, 2022). The concern is that purposeful sampling can introduce conscious bias in the selection of participants (Singh & Thirsk, 2022). However, to offset purposeful sampling, snowball sampling was used. Snowball sampling can limit bias as they are not directly recruited by the researcher but referred by the other participant (Ravitch & Carl, 2021). Snowball sampling allows the researcher to access hidden and vulnerable populations (Gray & Grove, 2021).

There are many different dialects of First Nation people's across Canada, with each group having very distinct and unique cultural beliefs, traditions, and ways of knowing. This study specifically focuses on Fort William First Nations people's in a Northern Ontario community. The recruitment sample is only from Fort William First

Nation which resulted in a homogenous sample. This specific Anishinabek First Nations community has its own cultural beliefs, traditions, ways of knowing and being that are different than other First Nations in Ontario like other Anishinabek, Mushkegowuk, Onkwehonwe, and Lenape that primarily make up Turtle Island which is now called North America (Chiefs of Ontario, n.d.-a). First Nations people's may be hesitant to engage in research due to a history of unethical research and colonialism (Bull et al., 2020; Loppie & Wien, 2022; Morisano et al., 2024).

Semistructured interviews are flexible and allow the researcher to adapt questions based on participant responses using open-ended questions (Gray & Grove, 2021). One weakness of interviews is interviewing bias where a researcher unwittingly leads an interviewee to answer a certain way, which is prominent in unstructured interviews (Singh & Thirsk, 2022). With the semistructured interviews, questions were developed from the Indigenous wholistic theory and were guided by the two-eyed seeing approach to limit bias. The interview questions were developed by the researcher and peer reviewed by the chair, committee, and knowledge holder. Field notes and member checking with participants can aid in reducing potential bias and ensuring the validity of findings (Burkholder et al., 2020).

### **Significance**

The proposed study fills the gap in understanding Northern Ontario First Nations people's experiences in receiving nursing care to meet their wholistic health needs. First Nations people's descriptions of receiving nursing care to meet their wholistic health needs are absent in the literature. Through this study, First Nation people's have an

avenue to describe their experiences of receiving nursing care to meet their wholistic health needs. First Nation people's are best positioned to answer the question of what they need to address their wholistic health care needs (Eni et al., 2021; Kennedy et al., 2022; Leclerc et al., 2020). First Nations people's descriptions of receiving nursing care must not be separated from their culture, relationships, or history. The history of colonialism and intergenerational trauma in all Indigenous peoples' has impacted their culture, relationships, and overall health for generations (Kyoon Achan et al., 2022).

### **Nursing Practice**

For nursing practice, understanding patients' health care experiences is crucial for quality improvement, performance measurement, high quality care, and value based care to strengthen health systems, improve clinical safety, and improve quality of care (Jamieson Gilmore et al., 2023). Nurses in practice report a lack of knowledge of Indigenous peoples' and caring for Indigenous peoples' (Barbo & Alam, 2024; Horrill et al., 2022; Leclerc et al., 2020). Nurses in practice have a professional and ethical responsibility to deliver culturally safe care to Indigenous peoples' that integrates their traditional knowledge, traditional healing, and traditional health beliefs (Canadian Nurses Association, 2017; College of Nurses of Ontario, 2023). First Nation participants can share their nursing experiences to highlight wholistic health needs, fostering a bridge between wholistic health of Indigenous ways of knowing and being and holistic care of Western knowledge (Morriseau & Fowler, 2023). Nurses in practice and nursing leaders can improve Indigenous peoples' health inequalities by integrating their wholistic health

needs into nursing care delivery and enhancing culturally appropriate training provided to nurses in practice (Kitching et al., 2020; Phillips-Beck et al., 2020; Wiley et al., 2021).

### **Nursing Education**

Nursing faculty report a lack of knowledge in understanding Indigenous peoples' health needs to integrate into curricula in response to accreditation standards (Doria et al., 2021; Hantke et al., 2022; Vass & Adams, 2021). Nursing faculty must integrate Indigenous health content into curricula in response to government mandates and accreditation standards (College of Nurses of Ontario, 2023; Metheny & Dion Fletcher, 2021; The Truth and Reconciliation Commission of Canada, 2015). This ultimately can lead to improved care. Nursing educators can understand Indigenous wholistic health needs to address their knowledge deficits of Indigenous health and integrate it into nursing curricula in response to the Truth and Reconciliation of Canada's Calls to Action and accreditation standards (Doran et al., 2019; Pitama et al., 2018; Morriveau & Fowler, 2023). Nursing students receiving nursing curricula integrated with Indigenous wholistic health needs enter practice prepared to care for Indigenous peoples' and deliver culturally appropriate care.

In describing and understanding Indigenous peoples' history, culture, and nursing care experiences, targeted nursing interventions and nursing education curricula can be developed to support nurses in delivering safe and culturally appropriate care to Indigenous peoples' (Blanchet Garneau et al., 2021; Burnside et al., 2023; Emanuelsen et al., 2023; Eni et al., 2021; Phillips-Beck et al., 2020). First Nations people's, through this qualitative study, can describe their experiences in receiving nursing care to meet their

wholistic health needs to support curriculum development, nursing practice training programs, and offer insights into their unique wholistic health needs to support future research and advocacy efforts.

The study results offer nursing educators, nursing leaders, and nurses in practice an opportunity to begin understanding and relating their current knowledge base to Indigenous peoples' wholistic health and ways of knowing and being. First Nations people's perspectives on their experiences receiving nursing adds new information to the literature and may create a junction between Indigenous peoples' and the biomedical of the health care system to integrate Indigenous knowledge into nursing care to improve their health outcomes and reduce disparities (Cassidy-Matthews et al., 2024; Eni et al., 2021; Horrill et al., 2022; Pilarinos et al., 2023).

### **Summary**

Chapter one explored the background of the historical and present health concerns Indigenous peoples' face through current and empirical evidence. Analyzing the current state of Indigenous health exemplified the need to respond to the Truth and Reconciliation Commission of Canada's (2015) Calls to Action through nursing education and practice. It was identified that to fully respond to government, accreditation, and regulatory policies, we must improve our understanding of First Nations people's experiences in receiving nursing care to meet their wholistic health needs. The chapter highlighted the problem, purpose of the study, the research question, the theoretical and conceptual framework, the nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance.

Chapter two explores the literature review process, and an exhaustive review of the literature related to the study's topic. At the beginning of Chapter Two, I explain the literature search strategy, the Indigenous wholistic theory, and the two-eyed seeing framework. The literature review explores the key concepts related to this phenomenon, which are Indigenous peoples' in Canada, the Truth and Reconciliation Commission of Canada, accreditation of nursing education programs and the regulation of nursing practice, nursing education, nursing practice, the Indigenous health landscape, and Indigenous peoples' wholistic health needs.

## Chapter 2: Literature Review

The Truth and Reconciliation Commission of Canada (2015), accreditation bodies of Nursing education programs, and regulatory bodies of nursing practice in Canada have developed calls to action, policies, guidelines, and entry-to-practice competencies to address Indigenous peoples' historical and current health status. Despite these efforts to address Indigenous peoples' health status, the nursing literature demonstrated a lack of research on Indigenous peoples' wholistic health needs while receiving nursing care. This qualitative study aimed to describe First Nation people's experiences in Northern Ontario when receiving nursing care to meet their wholistic health needs. This chapter includes the literature search strategy, the theoretical and conceptual framework, the literature review related to key concepts, and a summary.

### **Literature Search Strategy**

Relevant literature was identified using the following databases: PubMed, CINAHL, Nursing & Allied Health Database Premium (ProQuest), PsycARTICLES, Native Health Database, I-Portal Indigenous Studies Portal, and Google Scholar. The keywords and combinations of keywords were "Indigenous" and "nursing" and "holistic health" or "wholistic health" or "health care needs" and "nursing education." The keywords were expanded to include variations found in the previous searches of "Indigenous" or "Indian" or "Native" or "Aboriginal" or "First Nation" or "Inuit" or "Metis" or "Status" or "non-Status" and "nursing care" or "health care" or "health care" or "nursing practice" and "holistic health" or "wholistic health" or "health care needs" or health" and "nursing education" or "nursing faculty" or "nursing curriculum." There were

limited results when searching “holistic health” or “wholistic health,” so “health” was added. Additional search strategies were deployed to break the term holistic and wholistic health into “physical” or “emotional” or “spiritual” or “mental health.”

The search was limited to 2015 as a significant year of publication of the Truth and Reconciliation Commission of Canada’s (2015) report and subsequent impacts on the regulation and accreditation of nursing practice and nursing education. Older articles were included if they contained historical significance to the phenomenon under study. Over 350 articles were found using the search strategies. The results were reviewed to include only articles from Canada. Indigenous peoples’ have a unique history in Canada, and the current study’s focus was on nursing education and nursing practice, which differs globally. Secondary literature from federal and provincial publications, regulatory bodies, and accreditation bodies was included in the literature reviewed.

### **Theoretical Foundation**

The Indigenous wholistic theory encompasses Indigenous epistemologies, worldviews, cultures, and traditions derived from Indigenous and anticolonial knowledge and borrowed from the discipline of social work practice (Absolon, 2010). Absolon (2010) is an Anishinaabe Kwe from Flying Post First Nation, a professor, a researcher, and a social worker. The Indigenous wholistic theory is multilayered, cyclical, circular, and relational through integrating the medicine wheel; the seven generations past, present, and into the future; four directions; four domains of being; doorways of life; the ecology creation; and values (Absolon, 2010). The Indigenous wholistic theory includes the historical, social, political, and economic factors impacting an Indigenous person’s

sense of wholism, peace, balance, and harmony in life, which are explained through the four directions (Absolon, 2010; Fayed et al., 2018).

The Indigenous wholistic theory identifies the four major theoretical underpinnings of each direction: north, east, south, and west (Absolon, 2010). Absolon (2010) highlights that each of these directions is not mutually exclusive “in fact, they interrelate, interconnect, and are interdependent. Any change or movement in one area will affect the whole” (p. 78). The four directions contain the four elements to make up the wholism of physical, mental, emotional, and spiritual beings (Miles et al., 2023). All four directions and each sub concept are interconnected with the center of the four directions representing the fire of life and oneself (Absolon, 2010; Moscou, 2022).

### **Northern Direction**

The Northern direction acts as a key to the wholistic health of Indigenous peoples’ focusing on the physical domain of health, ceremony, and the colonial and economic factors impacting Indigenous peoples’ health. The physical health domain of health is the key to all other three doorways being in place for healing to occur (Absolon, 2010). The physical health domain of health incorporates healing, action, movement, ceremonies, restoring balance, and understanding the colonial impact on the diversity of Indigenous peoples’ (Absolon, 2010). The season of winter is attributed to the north (Absolon, 2010; Moscou, 2022). The north acknowledges economic factors of the social determinants of health have on one’s physical health and calls for movement in addressing the colonial history, the diverse needs of Indigenous peoples’, and the economic factors impacting Indigenous peoples’ (Absolon, 2010).

**Eastern Direction**

The eastern direction encompasses spiritual health as an interconnected aspect of all four domains of health through integrating vision, beginnings, and rebirth. The eastern direction represents spiritual health through new beginnings as the sun rises in the east and the season of spring represents new life (Absolon, 2010). Spiritual health involves the spirit, ancestral teachings, cultural knowledge and identity, history of colonialism and oppression, and honoring all relations with all of creation (Absolon, 2010). Spirituality must be considered within the context of healing as it is interconnected and interdependent amongst all four directions and four aspects of health (Absolon, 2010; Moscou, 2022). The teachings attributed to the east are vision, beginning, and rebirth. Absolon (2010) explains that vision is needed to “see the past, the present, and envision the future” (p. 78). Rebirth is recovering, reemerging, and reclaiming the Indigenous knowledge base that was lost due to colonialism (Absolon, 2010).

**Southern Direction**

The south direction represents emotional health and relational realms involving teachings of life, relationships, people, growth, reciprocity, and relationships (Absolon, 2010; Miles et al., 2023; Moscou, 2022). The season of summer is attributed to the south as it signifies renewal (Absolon, 2010). The teachings involve all relationships with humans, the natural world, and the spiritual world (Absolon, 2010; Moscou, 2022). Kinship is a strength of Indigenous peoples’ moving beyond just genetics to include all relational connections to individuals, families, communities, and clan systems (Moscou, 2022). Elders are a focal point of the south as they are the knowledge keepers of

Indigenous knowledge, culture, heritage, traditions and historical accounts (Absolon, 2010; Moscou, 2022). The social context is highlighted in the South to understand the socio-political context of many chronic diseases, intergenerational trauma, lateral violence, and multigenerational trauma (Absolon, 2010; Moscou, 2022).

### **Western Direction**

The western direction of wholistic health focuses on the mental domain through healing, recovery, and strengths. Mental health in the western direction asserts and operationalizes Indigenous knowledge as a healing source (Absolon, 2010). The western direction is attributed to the fall season for cleansing, harvesting, and taking care of one's body (Moscou, 2022). The west identifies asserting Indigenous knowledge as a strength to recover from colonial trauma and acknowledging ancestors, the cycle of life, dying, death, grief, and loss (Absolon, 2010). Cleansing the mind in this domain involves learning and applying Indigenous teachings, traditional medicines, and ceremonies to reconnect to the power of Indigenous identity (Absolon, 2010). The political context in the west acknowledges the harm colonialism has caused Indigenous peoples' and continues to plague Indigenous peoples' (Absolon, 2010; Moscou, 2022).

### **The Center**

The center of the Indigenous wholistic theory is the intersection of all four doorways collectively making up the whole of wholistic health. The center represents the coming together of all four directions through an interconnected and interrelated doorway where wholism, balance, and harmony must exist in oneself (Absolon, 2010; Fayed et al., 2018; Moscou, 2022; Richards, 2011). It is signified by fire and oneself including the

spirit, heart, mind, and body (Absolon, 2010; Miles et al., 2023; Moscou, 2022). The four doorways do not occur in isolation rather they occur in equal, interconnected, and interrelated portions to the live the good life wholistically.

First Nations peoples in Northern Ontario's nursing care experiences can be understood through the Indigenous wholistic theory and be used to guide practice through understanding the nature of balance, pace, and interconnectedness to achieve living the good life (Absolon, 2010; Moscou, 2022). "Indigenous peoples' experiences can be framed and contextualized within a historical, social, political, and economic context" (Absolon, 2010, p. 76). When a wholistic imbalance or disease occurs, it stems from the absence or attack of Indigenous worldviews, traditions, and identity (Absolon, 2010). Moscou (2022) used a qualitative approach with photovoice and focus group interviews to examine the key indicators of spiritual, mental, physical, and emotional wellbeing that Indigenous youth attributed to gardening.

Fayed et al. (2018) used a two-eyed seeing approach and the Indigenous wholistic theory to Indigenous perspectives on hepatitis C infection and determine appropriate interventions to target hepatitis C. Richard (2011) used an Indigenous wholistic theory to explore Indigenous students' experiences in higher education on their wholistic success. The Indigenous wholistic theoretical framework combined with circle teaching and Mino-Pimatiswiin approaches connect to the past, present, and future. Many researchers have used the Indigenous wholistic theory as a theoretical underpinning to support understanding the diverse and complex wholistic health needs of Indigenous peoples'.

The Indigenous wholistic theory supports the research problem, the gap, the research question, the methodology, the interview process, and data analysis. The Indigenous wholistic theory is rooted in Indigenous wholistic health beliefs and addresses the current research problem that it is not known what Indigenous peoples' experiences are when receiving nursing care to meet their wholistic health needs. The Indigenous wholistic theory further aligns with the methodology of ID as it allows participants to describe their experiences in receiving nursing care to meet their wholistic health needs. The interview guide can be developed from the key concepts of the Indigenous wholistic theory to gather participants' experiences.

### **Conceptual Framework**

The two-eyed seeing framework also called *etuaptmumk* was developed by Mi'kmaw Elder Albert Marshall from Eskasoni First Nation (Bartlett et al., 2012). The two-eyed seeing framework existed for many years before colonization and has been used as a framework, methodology, concept, guiding principle of practice, and in many strategic plans for companies (Bartlett et al., 2012; Rieger et al., 2020; Roher et al., 2021). As a framework, two-eyed seeing allows the researcher to integrate Indigenous knowledge alongside Western knowledge to weave between both worldviews and acknowledge both knowledge systems as equally important (Bartlett et al., 2012; Reiger et al., 2020; Wright et al., 2019). Roher et al. (2021) attest that understanding both Western and Indigenous knowledge systems independently can only offer a partial understanding of the world. Both Western and Indigenous knowledge systems, through

the two-eyed seeing framework are needed to understand fully the world (Roher et al., 2021).

The two-eyed seeing framework is common in current literature with the population focus of Indigenous peoples' as it recognizes and honors Western perspectives and Indigenous worldviews while encouraging self-reflection to evaluate assumptions, biases, and current knowledge (Asamoah et al., 2023; Gould et al., 2021; Kennedy et al., 2022; Pilarinos et al., 2023; Rieger et al., 2020; Wright et al., 2019). The two-eyed seeing framework can aid in decolonization in the research process to honor Indigenous ways of knowing and Indigenous research methodology (Kennedy et al., 2022; Fayed et al., 2018; Roher et al., 2021). Asamoah et al. (2023) & Kennedy et al. (2023) explain that the two-eyed seeing approach is a way in which Western biomedical models can meet Indigenous traditional healing ways of knowing for the benefit of all.

The two-eyed seeing framework informs the research methodology and the reflexivity of the researcher and provides an opportunity for the researcher to explore Indigenous health beliefs alongside Western health beliefs to enact positive social change to develop culturally appropriate interventions in practice and integrate Indigenous health content into nursing curricula. I am both of Indigenous and settler heritage, integrating both aspects of my heritage as I walk through life. My experiences of racism and discrimination have occurred at both aspects of my heritage for being too "White" to be Indigenous and too "Indigenous" to be a settler. As a practicing nurse and nursing educator, I have witnessed Indigenous peoples' in practice present with unmet health needs while having the Western biomedical model pushed as the only option to address

health care concerns. I have also witnessed racism and discrimination towards Indigenous patients from nurses and health care providers in the practice setting. As a nursing educator, I have witnessed nursing educators culturally appropriate Indigenous health content and knowledge while trying to integrate Indigenous content into curricula. I have collaborated with many non-Indigenous nursing educators who identify knowledge deficits in understanding Indigenous peoples' history, culture, and health needs.

Throughout my study, I have applied the two-eyed seeing framework. I am conscious of my identity as an Indigenous person and settler person and how this can potentially lead to bias in my study. Lynn (2010) explained that bias can occur if a researcher does not understand themselves and the biases they may be consciously or unconsciously bringing to a study. I used the two-eyed seeing framework to reflect on both knowledge bases I hold as I recruit participants, conduct interviews, analyze data, interpret data, and draw conclusions for nursing practice and nursing education. The two-eyed seeing framework was used to aid in analyzing the experiences of Indigenous peoples' in receiving nursing care to meet their wholistic health needs through a Western lens and an Indigenous lens.

### **Literature Review Related to Key Variables and/or Concepts**

The key concepts related to this phenomenon are Indigenous peoples' in Canada, the Truth and Reconciliation Commission of Canada, accreditation of nursing education programs and the regulation of nursing practice, nursing education, nursing practice, and the current Indigenous health landscape. Indigenous health landscape will be delineated into Indigenous health care funding, Indigenous health status, Western and Indigenous

wholistic health, Indigenous health care experiences, and Indigenous wholistic health descriptions.

### **Indigenous Peoples' in Canada**

In Canada, Indigenous peoples' are comprised of First Nation, Metis, and Inuit people (Government of Canada, n.d.-a). Indigenous peoples' are the fastest growing population, growing by 9.4% between 2016 and 2021, with 1.8 million or 5% of Canadians identifying as Indigenous (Government of Canada, n.d.-a). Indigenous peoples' are diverse, differing historically and geographically with a variety of subgroups that have different cultural beliefs and languages (Astle et al., 2024). Indigenous peoples' can live within their communities, rural settings, semi rural, or urban areas.

This specific study focused on First Nation people in Northern Ontario. According to the Chiefs of Ontario (n.d.-b), it is crucial to distinctly identify Indigenous peoples' into their respective groups of First Nation, Metis, or Inuit to ensure data is not low quality. It is representative of the needs of each group. There are one hundred and thirty three First Nations in Ontario alone, with each nation having a distinct identity, cultural beliefs, languages, and history from each other nation and, subsequently, Inuit and Metis people (Chiefs of Ontario, n.d.-b). First Nation people in Ontario can be status, non-status, and treaty Indians under the Indian Act (Astle et al., 2024). They can live on or off reserve, in urban, rural, or semirural areas.

### **The Truth and Reconciliation Commission of Canada**

The Truth and Reconciliation Commission of Canada's (2015) mandate is to acknowledge and identify the harm Indigenous peoples' face in Canada and commit to

the reconciliation of Indigenous peoples' to build a brighter future through ninety four calls to action of the government and Canadians in partnership with Indigenous peoples' to move towards reconciliation (The Truth and Reconciliation Commission of Canada, 2015). The purpose of the Truth and Reconciliation Commission of Canada was to explore and examine the truth of what happened in Residential Schools impacting First Nations, Inuit, and Metis people in Canada and to develop calls to action for the government and Canadians to reconcile with Indigenous peoples' in Canada. These Calls to Action address the colonial roots of health disparities of Indigenous peoples' and pave a clear path for the role of nursing programs to integrate culturally competent care of Indigenous patients into curriculums (Wylie et al., 2019).

The Truth and Reconciliation Commission of Canada (2015) identified 94 calls to action with four applicable to nursing practice and education. Call to Action eighteen addresses the cause of the current state of Indigenous peoples' health as directly relational to the Canadian Government's policies, treaty implementation, and the failure to address Indigenous peoples' health care rights (The Truth and Reconciliation Commission of Canada, 2015). Call to Action twenty two calls for the collaboration of Indigenous healers and elders in the care of Indigenous patients and recognizing and integrating Indigenous healing approaches in care (The Truth and Reconciliation Commission of Canada, 2015). The Truth and Reconciliation Commission of Canada (2015) Call to Action twenty three calls for the government to increase and retain Indigenous health care professionals and to ensure all health care providers receive cultural competency training (The Truth and Reconciliation Commission of Canada,

2015). Call to Action twenty four calls for a specific course and training in an antiracism approach integrating Indigenous teachings and practices, the history of Residential Schools, Indigenous health issues, Indigenous rights and treaties, and the United Nations Declaration on the Rights of Indigenous peoples' (The Truth and Reconciliation Commission of Canada, 2015).

### **Accreditation and Regulation of Nursing Education and Practice**

The Truth and Reconciliation Commission of Canada, provincial and federal regulatory bodies, and accreditation standards in Canada require nursing curriculums to ensure nursing graduates are prepared to provide cultural care for Indigenous peoples' to reduce their health inequalities (Doria et al., 2021; Wiley et al., 2021). Nursing education programs and nursing practice are regulated through provincial regulatory bodies. Whereas accreditation for nursing education is regulated both provincially and federally. The Canadian Nurses Association (CNA) (n.d.) highlights their position statement and beliefs in promoting cultural competence in nursing, which can foster cultural safety in caring for Indigenous peoples' and addressing Indigenous health needs. The CNA's (n.d.) core competencies focus on post colonial understanding, communication, inclusivity, respect, Indigenous knowledge, and mentoring/supporting students for success, all built on two foundational concepts through a constructivist understanding of culture and cultural safety. The Canadian Nurses Association (2017) Code of Ethics outlines value F of promoting justice to include not discriminating against a person based on race, ethnicity, or culture and respecting the history and interests of Indigenous peoples' outlined in the Truth and Reconciliation Commission of Canada. The CNA (2017)

recognizes the need to urgently integrate Indigenous health in nursing curricula and practice as a moral and ethical responsibility to prepare graduates to deliver culturally competent and culturally safe care to Indigenous peoples' in Canada.

In December 2023, the Canadian Association Schools of Nursing (CASN), which is responsible for nursing education accreditation at a federal level, issued a public apology to Indigenous peoples' in Canada for harm, historical or contemporary, related to nursing education that perpetuates system racism and a failure to integrate Indigenous perspectives and the impact of colonialism into nursing education. Nursing faculty teaching in nursing programs identify a lack of knowledge of Indigenous peoples', their history, and Indigenous peoples' current reality (Wiley et al., 2021). Nursing and health care programs have an insufficient comprehensive Indigenous health curriculum, with very few programs integrating any Indigenous health curriculum (Metheny & Dion Fletcher, 2021; Pitama et al., 2018).

On February 13<sup>th</sup>, 2025, the Canadian Association Schools of Nursing (CASN) released Cultural Humility and Cultural Safety Standards for Nursing Education (Canadian Association Schools of Nursing, 2025). The standard integrates evidence based informed standards and clear behavioural and knowledge learning outcomes for nursing students with a focus on nursing educators ensuring their curricula delivery is antiracist, nondiscriminatory, decolonized, and a strength-based approach (Canadian Association Schools of Nursing, 2025). The standards are broken down into subdomains with specific learning outcomes related to the standards of colonization, colonialism, and genocide, Indigenous specific racism in practice and health care, cultural humility and

cultural safety, Indigenous knowledge and practices for health, and collaboration with First Nation, Inuit, and Metis communities and organizations (Canadian Association Schools of Nursing, 2025).

In 2020, The Colleges of Nurses of Ontario (CNO), as the regulatory body in Ontario responsible for nursing education and nursing practice in Ontario, mandated new entry to practice competencies for both the Registered Nurse and the Registered Practical Nurse reflecting and responding to the Truth and Reconciliation Commission of Canada (2015) Calls to Action (College of Nurses of Ontario, 2019). The CNO mandated integrating the Truth and Reconciliation Commission of Canada's (2015) Calls to Action (23 & 24) into nursing curriculums as part of the entry to practice competencies for registered nurses and registered practical nurses (College of Nurses of Ontario, 2019). Nursing programs across Ontario are required to adjust the curriculum to reflect this new entry to practice competencies. As part of the approval process, nursing programs must describe and demonstrate that they have successfully integrated entry-to-practice competencies into the curriculum through a mapping process.

Although the entry-to-practice competencies for program approval differ slightly between registered nurses and registered practical nurses, both entry-to-practice competencies attest that students must ascertain knowledge of the Truth and Reconciliation Commission of Canada Calls to Action, Indigenous history and integrate Indigenous ways of knowing and being into their practice. As an example, the Bachelor of Science in Nursing (BSN) program's competency framework identifies that the registered nurse must engage in self-reflection to address biases, acknowledge the Calls

to Action, advocate for the use of Indigenous health knowledge and healing practices, advocate for health equity, acknowledge health disparities, and optimize health outcomes (College of Nurses of Ontario, 2019). College of Nurses of Ontario (2023) Code of Conduct principle two defines cultural safety and cultural humility. Nurses must provide inclusive and culturally safe care through self-reflection, creating safer health care experiences, and training and education.

### ***Nursing Practice***

Nurses in practice are not prepared well to care for Indigenous peoples'. Nurses in practice caring for Indigenous peoples' report low self-efficacy and knowledge of Indigenous patients' health needs (Leclerc et al., 2020). There is a lack of understanding of Indigenous peoples' health needs, specifically personal health management, which includes traditional healing methods and cultural values and beliefs (Berg et al., 2019; Cassidy-Matthews et al., 2024; Horrill et al., 2022; Tremblay et al., 2020). Inuit patients in Northern Canada who received nursing care reported a lack of respect for cultural practices, appropriate services, continuity in care, colonial legacy perceptions, and experiences of poor quality of care (Cooper et al., 2021). Nurses lack the cultural competence to care for Indigenous patients, thus contributing to poorer health care outcomes and health care inequalities for Indigenous peoples' (Metheny & Dion Fletcher, 2021; Wylie et al., 2021). Leclerc et al. (2020) found that 90% of the nurses who participated did not receive formalized training about Indigenous cultural practices. Similarly, Wiley et al. (2021) attested that the current training of nurses in practice has notable gaps including a lack of knowledge of Indigenous peoples', history, issues

Indigenous peoples' face in everyday life, and the current reality of Indigenous peoples'. Wu et al. (2023) note that inadequate training programs facilitate ignorance, and a lack of understanding of Indigenous knowledge systems leads to culturally unsafe practitioners.

### ***Nursing Education***

Despite nursing regulation, accreditation standards, government mandates, and the Truth and Reconciliation Calls to Action, nursing education is not fully prepared to ensure nursing students are prepared to care for Indigenous peoples'. There is a weakness in health education in Canada when it comes to training professionals on Indigenous health has many inconsistencies about Indigenous health needs in postsecondary programs (Morriseau & Fowler, 2023; Turpel-Lafond, 2020; Yaphe et al., 2019). The health education curriculum continues to colonize Indigenous peoples' through diminishing Indigenous knowledge, promoting assimilation and cultural genocide, increasing power imbalances among health care professionals, and decreasing Indigenous health care professionals (Blanchet Garneau et al., 2021; Wilson et al., 2020). There is a need for improved education for nursing students on Indigenous cultural competence. Indigenous patients who received Western health care noted that Indigenous cultural safety education is necessary for all health care involved staff (Pilarinos et al., 2023).

The literature highlights that health programs do not prepare graduates to deliver adequate cultural competence to Indigenous peoples', and very few programs have integrated the Calls to Action or Indigenous health content adequately (Doria et al., 2019; Doria et al., 2021; Metheny & Dion Fletcher, 2021; Pitama et al., 2018). Metheny & Dion Fletcher (2021), through their environmental scan, determined only 17.8% of

programs met the research criteria for adequate cultural safety inclusion for Indigenous students and only 18.7% adequately satisfied call to action number 24 of integrating Indigenous content into curricula. Similar studies found that where Indigenous competence integration into the curriculum occurred, it focused on a single course or course module and often was not compulsory or throughout the curriculum (Blanchet Garneau et al., 2021; Metheny & Dion Fletcher, 2021; Wiley et al., 2021). Indigenous health content should be integrated early into curricula and scaffolded throughout the curricula and should mirror the competencies, roles, and responsibilities of nurses in their practice as required by nursing education accreditation and the regulatory provincial bodies in where the nurses practice. (Blanchet Garneau et al., 2021; Wiley et al., 2021).

Nursing educators need to understand Indigenous peoples' wholistic health needs to develop, align, and deliver their curriculum to prepare nursing students to care for Indigenous patients. Yet, nursing educators highlight their deficiencies in integrating Indigenous health content due to a lack of understanding of Indigenous peoples', their history, and the issues Indigenous peoples' face in everyday life (Doria et al., 2021; Hantke et al., 2022; Metheny & Dion Fletcher, 2021; Pitama et al., 2018; Vass & Adams, 2021). Nursing educators further note they struggle with their perception of themselves, confidence, Indigenous teaching strategies and pedagogy, their personal interest, and identifying patterns of racism/Whiteness through power analysis (Doria et al., 2021; Hantke et al., 2022; Metheny & Dion Fletcher, 2021; Pitama et al., 2018; Vass & Adams, 2021; Wiley et al., 2021).

Weaving Indigenous knowledge into nursing curricula should involve Indigenous voices. Indigenous perspectives and Indigenous knowledge must focus on including Indigenous peoples' values, beliefs, culture, tradition, and languages through their unique Indigenous context (Canadian Association Schools of Nursing, 2025; Van Bower et al., 2020). Understanding Indigenous knowledge and ways of knowing should come from Indigenous peoples' in a strength-based approach to foundational knowledge to aid in curriculum development (Blanchet Garneau et al., 2021; Canadian Association Schools of Nursing, 2025; Kennedy et al., 2022; Van Bower et al., 2020; Wiley et al., 2021). Health care workers and nurses must be taught about Indigenous peoples' history, cultures, traditions, and health needs (Cooper et al., 2021; Van Bower et al., 2020; Vigneault et al., 2021).

### **Indigenous Health Care Funding**

First Nation health care funding and delivery in Canada is the Federal government's responsibility on reserves as outlined in the Indian Act of 1985 and Treaties (Astle et al., 2024; Vigneault et al., 2021). Although First Nations people can self-govern according to the Constitution of 1982, not all agreements include health (Government of Canada, n.d.-g). Health care funding and delivery through direct transfers from the federal government only covers status members of First Nations living on reserve and receive health care funding through direct transfers from the federal government (Government of Canada, n.d.-g). Off reserve First Nations and non-status First Nations receive and access health care from provincial and territory funding falling under the principles of the Canadian Health Act (Government of Canada, n.d.- g).

The literature demonstrates that Canada's current health care system does not meet Indigenous peoples' needs (Josewski et al., 2023; Matheson et al., 2022; Phillips-Beck et al., 2020; Wu et al., 2023). There are limited funding and limited access to health care services for on-reserve Indigenous peoples' are major barriers (Josewski et al., 2023; Matheson et al., 2022; Phillips-Beck et al., 2020). For off-reserve members, accessing health care in urban or semi urban settings demonstrates a lack of equity in health services, lack of cultural care or knowledge of Indigenous culture, discrimination, prejudice, and racism (Kitching et al., 2020; Lecrlec et al., 2020; Turpel-Lafond, 2020; Wrathall et al., 2020).

### **Health Status of Indigenous peoples'**

The health status of Indigenous peoples' in Canada is well below the Canadian average with a shorter life expectancy (Marchildon et al., 2021; McVicar et al., 2021; Pilarinos et al., 2023; Vigneault et al., 2021). Despite the growing Indigenous population in Canada, the prevalence of longstanding health disparities and significant health outcome gaps for Indigenous peoples' remains elevated compared to non-Indigenous peoples' (Hahmann & Kumar, 2022; Josewski et al., 2023; Kyoon Achan et al., 2022; Matheson et al., 2022; Turpel-Lafond, 2020; Yangzom et al., 2023). Indigenous peoples' in Canada continue to be impacted by social determinants of health of access to health care, food security, clean drinking water, education, health literacy, social support, homelessness, income, poverty, and environmental containments like mercury or pollutants (Batal et al., 2021; Cooper et al., 2021; Eni et al., 2021; Horrill et al., 2022; Joo-Castro et al., 2021; McVicar et al., 2021; Vervoort et al., 2022). For Indigenous

peoples', adequate housing is linked to a direct cause or exacerbation of illnesses like tuberculosis and other respiratory issues (Matheson et al., 2022). Unemployment is directly related to psychological wellbeing (Durand-Moreau et al., 2022).

Indigenous peoples' have an extremely high prevalence of chronic disease and mortality compared to non-Indigenous peoples'. The prevalence of diabetes, arthritis, asthma, obesity, respiratory disease, and mental illness remains higher for Indigenous peoples' in Canada than for non-Indigenous peoples' (Chang et al., 2024; Loyola-Sanchez et al., 2020; Public Health Agency of Canada, 2018). As diagnosed by a health care provider, over 59.8% of Indigenous peoples' have at least one chronic condition (First Nation Information Governance Council, 2018). Diabetes poses a risk of eight to ten times higher for Indigenous peoples' compared to half of the general population (Hayward et al., 2020). Chronic kidney disease risk for Indigenous peoples' is twice that of non-Indigenous peoples' and has a 77% higher mortality risk factor (Lee & Battistella, 2019). Metis has a 25%-77% higher prevalence rate of cardiovascular diseases compared to the general population, and First Nations have a 2.5 times prevalence of cardiovascular disease than the general population (Vervoort et al., 2022).

### **Western Health Care Experiences**

When receiving health care in Western care facilities, Indigenous peoples' reported experiences of racism, discrimination, prejudice, and barriers to adequate care of lack of access, lack of communication, and lack of knowledge of Indigenous culture, ways of knowing and being. The prevalence of discrimination, prejudice, and racism experienced by Indigenous peoples' when accessing and receiving Western health care

remains unprecedented and closely connected to Indigenous peoples' increasing health disparities and health inequities. Racism, discrimination, and prejudice directly increase the health inequities of Indigenous peoples' (Barbo & Alam, 2024; Joo-Castro et al., 2021; Phillips-Beck et al., 2020). Joyce Echquan and Brian Sinclair were two Indigenous peoples' in Canada who died because they were victims of racism, prejudice, and discrimination by health care providers in Western care facilities (Browne et al., 2022; Graham, 2024; Phillips Beck et al., 2020; Wiley et al., 2021).

### ***Discrimination, Racism, and Prejudice***

The presence of discrimination and racism are barriers to Indigenous peoples' receiving culturally appropriate and culturally safe care (Batal et al., 2021; Cooper et al., 2021; Josewski et al., 2023; Pilarinos et al., 2023; Turpel-Lafond, 2020). There is a crude relationship between discrimination by a health care provider and reports of unmet health needs (Kitching et al., 2020). Kitching et al. (2020) found that 28.5% of Indigenous participants experienced discrimination by health care providers, with a total of 27.3% of participants reporting unmet health needs. Racism leads to distress, stress, suicidal ideation, increased use of mood altering substances, and poorer health outcomes for Indigenous peoples' (Turpel-Lafond, 2020).

Colonialism and Indigenous peoples' history in Canada continue to impact their experiences of racism, discrimination, and prejudice when accessing and receiving health care, increasing health disadvantages for Indigenous peoples' (Nguyen et al., 2020; Pilarinos et al., 2023; Veroort et al., 2022). Gall et al. (2021) found that Indigenous participants reported personal and collective experiences of disempowerment,

marginalization, loss of land, and racism have adversely impacted their health and wellbeing. Nelson & Wilson (2018) found that Indigenous patients reported experiences of racism and discrimination impacted their access to health care. Goodman et al. (2017), Indigenous participants in Vancouver's inner city reported negative health care experiences involving racial stereotypes and dismissive care negatively impacting Indigenous participants' care received or delays in care received. Graham (2024) explains that there is a need for urgent and consistent intervention needed to address racism Indigenous peoples' face in health care. Graham (2024) developed CPR Racism: A guide for health care providers to disrupt and dismantle racism in health care.

### ***Barriers to Adequate Care***

Indigenous patients note significant barriers in their Western health care experiences related to lack of access, lack of communication, and lack of knowledge of Indigenous culture, ways of knowing and being. Yangzom et al. (2023) found that having a regular health care provider for Indigenous peoples' is a huge barrier to receiving adequate care, with:

significantly higher proportions of First Nations people living off reserve (20.3%), Métis (17.9%) and Inuit (56.5%) reported being without a RHCP compared with the non-Indigenous population (14.5%). Eight in ten Inuit and one half of off-reserve First Nations people and Métis living in very remote areas in 2017-2020 did not have a regular health care provider. (p. 7)

Many Indigenous communities do not have road access to their communities, further restricting their access to health care and resulting in increased travel to receive care (Burnett et al., 2020; Nguyen et al., 2020; Smylie et al., 2021).

Ineffective communication, over usage of medical jargon leading to misinterpretation, and a lack of ability to use traditional language and communication methods negatively impact their health care experience and care received (Cooper et al., 2021; Loyola-Sanchez et al., 2020; Tremblay et al., 2020; Wu et al., 2023). Indigenous participants explained that health care providers do not understand or have knowledge of Indigenous traditional practices, cultural perspectives of health, and spiritual concepts of disease (Tremblay et al., 2020). Pilarinos et al. (2023) found Indigenous participants felt health care providers dismissed their culture, ceremony, and traditional knowledge when receiving Western care. The lack of Indigenous history and culture was reported by both nursing educators and nurses in practice (Leclerc et al., 2020; Doria et al., 2021).

### **Western Holistic Health and Indigenous Wholistic Health**

The current health care delivery model and nursing interventions focus solely on the Western biomedical model and do not integrate Indigenous cultural values, worldviews, ways of knowing, or conception of health (Horrill et al., 2022; Phillips-Beck et al., 2020; Vervoort et al., 2022; Wu et al., 2023). Asamoah et al. (2023) and Eni et al. (2021) note that Western biomedicine focuses heavily on the anatomical/physiological body and disease through scientific means, neglecting the wholistic health and wellbeing approach to First Nation people. Holism is a concept prominent in nursing that was first introduced by Florence Nightingale and is prominent in nursing practice and nursing

education, which support the Western biomedical science approach (Eni et al., 2021; Kennedy et al., 2022; Morriseau & Fowler, 2023; Van Beyer et al., 2020). Holism stems from the history of Western religion, philosophy, and medicine (Eni et al., 2021; Van Beyer et al., 2020)

Indigenous peoples' definition of wholism "includes a broader definition of healing and caring including concepts such as balance, culture, relationships, male, female, non-compartmentalization, flowing with harmony, and pursuing peace" (Van Beyer et al., 2020, p. 14). Indigenous peoples' definition is non-linear, interconnected, and cyclic positioned in Indigenous ways of knowing and being to reflect the interconnectedness of the mind, body, heart, and spirit (Miles et al., 2023). When exploring Indigenous peoples' wholistic health needs, it is well documented that Indigenous worldviews encompass a wholistic view of health where the balance between physical, emotional, mental, and spiritual domains is key to health (Barnabe, 2021; Batal et al., 2021; Gall et al., 2021; Moscou, 2022; Ryan et al., 2020; Vervoort et al., 2022). Abolson's (2010) Indigenous wholistic theory identifies wholistic health as an interconnected cyclical, ecological, and relational being of Indigenous peoples' that includes historical, social, political, and economic factors impacting the four directions and the four domains of health.

Through a systematic review, Gall et al. (2021) found that Indigenous worldviews of wholistic health in Canada encompass culture, identity, language, community, land sea, resilience, cultural medicine, and physical, mental, emotional, and spiritual domains of health. Yet, Indigenous wholistic health needs in receiving nursing care remain absent

in the literature. The literature focuses on Indigenous peoples' experiences of Western health care, Indigenous-focused or Indigenous-led health care, or only single domains of health of physical, emotional, spiritual, and mental

### **Indigenous-focused Health Care Experiences**

When accessing Indigenous-focused or Indigenous-led health care centers, Indigenous patients reported positive experiences and can improve health outcomes for Indigenous peoples' (Allen et al., 2020; Pilarinos et al., 2023). Indigenous-focused health care centers integrate wholistic Indigenous approaches, integrate Indigenous knowledge, values, and culture as healing, patient orientated, ability to practice culture and spirituality and focus on the interconnectedness of all people, the natural environment, and the spiritual world (Kyoon Achan et al., 2022; Wu et al., 2023). Indigenous patients who accessed Indigenous specific services in an urban Indigenous health clinic described their experiences as a strong sense of trust in their health care providers, feeling dignified, receiving a wholistic approach to health and wellbeing, and feeling health care providers provided an equal weight to Western medicine and traditional healing (Pilarinos et al., 2023).

### **Physical Health**

Within physical domains of health, the current literature focuses on chronic disease. This aligns with Eni et al. (2021) and Asamoah et al. (2023) who highlight that Western biomedicine focuses on anatomy, physiology, disease, and healing through scientific means. Physical health is identified within Indigenous knowledge as a key link between all doorways of the health of mental, spiritual, and emotional (Absolon, 2010;

Moscou, 2022). If one of the other domains of health is imbalanced, healing cannot occur (Absolon, 2010). For Indigenous peoples', their physical health is directly impacted by economic factors of the social determinants of health. Many researchers have explored Indigenous patient's experiences living with certain chronic diseases like arthritis, liver transplants, diabetes, or cardiovascular disease (Cassidy-Matthews et al., 2024; Loyola-Sanchez et al., 2020; Tremblay et al., 2021; Vervoort et al., 2022).

An Indigenous liver transplant participant reported that the medical procedure of a transplant was not just a physical procedure; it involved spiritual and cultural connections to health (Cassidy-Matthews et al., 2024). Traditional healing practices and ceremonies are a source of strength when undergoing a physical health concern (Cassidy-Matthews et al., 2024). When faced with a physical health concern like a chronic disease, Indigenous patients need the opportunity to learn about their biomedical disease and require the integration of Indigenous traditional healing into their care (Loyola-Sanchez et al., 2020; Tremblay et al., 2021). Beyond these chronic disease experiences or physical Western diagnoses, Indigenous peoples' report physical health is impacted by many social determinants of health like housing, transportation, food security, finances, employment exercise, diet, and lifestyle (Durand-Moreau et al., 2022; Gall et al., 2021; Matheson et al., 2022; Tremblay et al., 2021). This aligns with the Indigenous wholistic theory's domain of the north and physical health, which is impacted by the socioeconomic context (Absolon, 2010).

## **Emotional Health**

Emotional health involves culture, balance, and relationships with family and community and is intertwined with other domains of health (Gall et al., 2021; Vervoort et al., 2022). Abolson (2010) and Moscou (2022) explain that emotional well-being is directly interconnected to the community and fosters quality relationships. Many Indigenous communities feel the effects of colonial history directly impacting their emotional health individually and collectively as a community (Gall et al., 2021; Goodman et al., 2017; Matheson et al., 2022). Dispossession of land historically and presently negatively impacts the emotional health domain of Indigenous peoples' (Matheson et al., 2022). Indigenous peoples' often have to access health care outside of their Indigenous communities, leaving behind their families, community, and land (Horrill et al., 2018; Nguyen et al., 2020). Ironside et al. (2020) found that First Nations and Cree/Nehiyaw participants with a high physical activity level had a stronger cultural connectedness. There is an opportunity to improve the emotional health of Indigenous peoples' and relationships with Indigenous peoples' through strength-based interventions that focus on relationality, disrupting racializing stereotypes, humanizing interactions with dignity and respect, and honoring collectivism and interconnectedness of all people and all beings (Kennedy et al., 2022).

## **Spiritual Health**

Spiritual health is interconnected with all domains of health, including the environment (Kyoon Achan et al., 2022; Matheson et al., 2022; Vervoort et al., 2022). This is echoed in the Indigenous wholistic theory where Abolson (2010) and Moscou

(2022) highlight the spiritual domain within the eastern direction is interconnected and interdependent amongst all four aspects of health and all four directions. The spiritual domain of health involves a balance of cultural medicines, traditional healers, cultural medicines, the creator or mother nature connection, and ceremonies like smudging, sweat lodges, and dances (Gall et al., 2021). Kyoon Achan et al. (2022) elaborate that spiritual health is living a whole, healthy, and balanced life on the red road. Kyoon Achan et al. (2022) found that access to traditional healing, traditional help, spiritual elders, and sweat lodges strengthens the spiritual health of Indigenous peoples'. Indigenous women reported culture, teachings, and ceremony (smudging, prayer, sweats, circles, traditional medicines) were significant to their spirituality in healing from life experiences, specifically inter-partner violence (Ogden & Tutty, 2024). Spirituality continues to be of growing importance for Indigenous peoples' (Burnett et al., 2022).

Spiritual health is impacted by colonial history with the loss of cultural knowledge due to colonialism, loss of language, and loss of cultural practices (Matheson et al., 2022). Presently, many Indigenous peoples' report that health care providers do not have knowledge of their culture and traditions (Pilarinos et al., 2023; Tremblay et al., 2020). Similarly, Nurses in practice reported not knowing Indigenous peoples' cultural needs (Leclerc et al., 2020). Nursing educators reported the lack of knowledge of Indigenous culture and history as a barrier to integrating Indigenous content into curricula (Doria et al., 2021; Hantke et al., 2022; Metheny & Dion Fletcher, 2021; Vass & Adams, 2021). Indigenous elders attest that understanding and respecting Indigenous knowledge and healing practices that revitalize culture and collective identity is a strength-based

approach to improving health care professionals' ability to care for Indigenous peoples' and an opportunity for health care professionals to improve their curricula (Kennedy et al., 2022). Subsequently, this would improve Indigenous peoples' spiritual health and health equity.

### **Mental Health**

Gall et al. (2021) and Vervoort et al. (2022) note that mental health is interconnected with all aspects of health and is heavily impacted by colonial history. Absolon (2010) captured this in the Indigenous wholistic theory, noting that mental health in the West direction involves the teachings of ancestors, respect, rebuilding and recovering from colonial trauma, re-emergence of knowledge, and the political context related to Indigenous peoples' loss of culture, language, traditions, land, and family through the mechanisms of colonization.

Indigenous peoples' have high rates of mental illness (Chai, 2024; Eni et al., 2021; Gone & Kirmayer, 2020; Gould et al., 2021). Mental health problems in Indigenous peoples' have been classified as endemic among Indigenous peoples' (Matheson et al., 2022). Chai (2024) explains that Indigenous peoples' are "three and two times more likely to die by suicide compared to their non-Indigenous counterparts," while Inuit people are "nine times more likely to die by suicide than non-Indigenous peoples' (Chai, 2024, p. 611). Gall et al. (2021) and Vervoort et al. (2022) highlight that mental health is heavily impacted by colonial history. It is formally recognized that historical colonial trauma and Residential Schools have impacted Indigenous peoples' health in present generations (Horrill et al., 2018; Wright et al., 2019). Indigenous

peoples' to this day still feel the impacts of colonialism and assimilation presently and for future generations to come which is now referred to as Intergenerational trauma (Matheson et al., 2022; Smallwood et al., 2020; Turpel-Lafond, 2020).

Burnett et al. (2022) explained that Indigenous participants who reported a decreased sense of community belonging had two times the higher odds of reporting poor mental health. This is echoed through a study focusing on Indigenous men's mental health. Indigenous participants explained that losing relationships, identity, and belonging to an Indigenous community negatively impact their emotional health in healing their mental health (Waddell et al., 2021). Similarly, in the same study, Indigenous participants explained that mental health healing required ceremony and connections to the land (Waddell et al., 2021). Through a scoping review, Smallwood et al. (2021) found that connections to family, community, and culture were protective factors that fostered resilience to historic trauma and mental health.

### **Summary and Conclusions**

Since the colonization of the Indigenous peoples' lands, Indigenous peoples' have experienced many efforts to eradicate and assimilate them through Residential Schools, the Sixties Scoop, the Indian Act, and Treaties throughout history. These attempts at colonization have left a long lasting impact on Indigenous peoples' health fostering health inequities, high chronic disease prevalence, poor health outcomes, and deficiencies in the social determinants of health. The Truth and Reconciliation Commission of Canada, the UNDRIP, legislation, changes to accreditation bodies of Nursing education programs and regulatory bodies of Nursing practice, and research have advocated to

address the current health status of Indigenous peoples' and the prolonged health inequities they face.

Despite these advocacy efforts, Indigenous peoples' continue to receive the projected Western biomedical model when accessing Western health care. Indigenous peoples' highlight experiences of racism, discrimination, prejudice, and barriers to adequate care, resulting in unmet health needs. There have been movements to integrate and collaborate with Indigenous communities and Indigenous peoples' to deliver Indigenous-focused or Indigenous-led care, which has proven to be effective for Indigenous peoples'. In analyzing Indigenous peoples' perceptions or experiences, they grouped together as Indigenous peoples' and focused on a single domain of health physical, mental, emotional, or spiritual. Yet, Indigenous participants often referenced other domains of the Indigenous wholistic theory (Abolson, 2010) in their responses. It is evident there is an interconnectedness between each domain. Yet, First Nations people in Northern Ontario's experiences of receiving nursing care to meet their wholistic health needs have not been addressed.

There is an opportunity to explore and analyze Indigenous peoples', specifically First Nations, perspectives in Northern Ontario in receiving nursing in meeting wholistic health needs. Indigenous peoples' have the right to self-determination of their health and health care needs (Barnabe, 2021; Eni et al., 2021; Kyoon Achan et al., 2022; Phillips-Beck et al., 2020; Nguygen et al., 2020; Redvers & Blondin, 2020; Wu et al., 2023). Understanding Indigenous peoples' wholistic health needs can bridge the gap between Western health beliefs and Indigenous health beliefs (Vervoort et al., 2022). First

Nation's experiences in receiving nursing care to meet their wholistic health is a notable and important gap in the literature that needs to be addressed through this study (Eni et al., 2021; Kyoon Achan et al., 2022; Loyola-Sanchez et al., 2022; Pilarinos et al., 2023; Turpel-Lafond, 2020).

Many researchers call on research, nursing practice, and nursing education to engage Indigenous peoples' to share their voices and unique experiences that can address and improve Indigenous peoples' health (Barbo & Alam, 2024; Batal et al., 2021; Vincze et al., 2021; Wu et al., 2023). It is a requirement under the Truth and Reconciliation Commission of Canada's (2015) Calls to Action 22 and the UNDRIP (Government of Canada, 2023; The Truth and Reconciliation Commission of Canada, 2015). Asamoah et al. (2023) and Kennedy et al. (2022) identify that using a two-eyed seeing framework provides an opportunity to explore Indigenous peoples' cultural traditions and ways of knowing and being alongside Western health beliefs. Kennedy et al. (2022) clearly explain that using the two-eyed seeing approach allows Indigenous peoples' and health care providers or health profession educators to engage as co-learners and make positive changes in health care and health professions education.

In this chapter, I explored the literature search strategy, the theoretical and conceptual framework, and reviewed the literature related to key concepts. In the next chapter, chapter three focused on the research design, rationale of interpretive description design, and the role of the researcher with alignment to the gap in the literature of First Nation people in Northern Ontario's experiences in nursing care to meet their wholistic health needs. The research methodology is enumerated to include participant selection

and recruitment, data collection, data analysis plan, issues of trustworthiness, and ethical procedures.

### Chapter 3: Research Method

This interpretive description qualitative study aimed to describe the experiences of First Nation people in Northern Ontario regarding their reception of nursing care to meet their wholistic health needs. The results from this study may aid in bridging the gap between Western holistic health care and Indigenous wholistic health needs to support developing targeted nursing interventions in nursing practice, elicit nursing curriculum changes to respond to government and accreditation mandates, and support future research to develop Indigenous health policy and improve Indigenous peoples' health. Chapter 3 includes a description of the research design and rationale, my role as the researcher, and the methodology. The methodology section includes participant selection, recruitment, sample size, data collection instrument, interview process, data analysis, issues of trustworthiness, and ethical procedures. Thorne (2019) called on the nursing profession and researchers to "actively challenge the influences that have shaped the thinking of all of us and make space for marginalized Indigenous perspectives, in other words, acknowledging the rightful power and place within the society of Indigenous persons" (p. 2). With this in mind, Western methodologies were guided in the current study by the two-eyed seeing framework as an Indigenous methodology.

#### **Research Design and Rationale**

The research problem was the lack of understanding of what First Nation people in Northern Ontario experience in receiving nursing care to meet their wholistic health needs. The study aimed to answer the following research question: What are the experiences of First Nation people's in Northern Ontario in receiving nursing care to

meet their wholistic health needs? The study was grounded in the Indigenous wholistic theory (Abolson, 2010) and the two-eyed seeing framework (Bartlett et al., 2012; Rieger et al., 2020; Roher et al., 2021). The study was a basic qualitative study using an interpretive description design (ID).

The interpretive description design does not prescribe or detail sequences of steps but rather allows for the options to integrate all design approaches into the research process that align with the research question (Thorne, 2016). The interpretive description design is a balance of current clinical knowledge or wisdom and what is known with empirical means to highlight new insights to shape inquiries and translate them into practice (Thompson Burdine et al., 2020). Interpretive description approaches can elicit usable knowledge for practical application for clinicians through understanding the complex human experience (Ocean et al., 2022; Thompson Burdine et al., 2020; Thorne, 2016; Wright et al., 2019)

Interpretive description involves both description and interpretation aspects of the methodology. The description is an open and exploratory process using inductive reasoning to generate descriptions of the human experience (Thorne, 2016). Interpretation is a human social phenomenon, socially constructed by the subjective people who experience it and the intersubjective experience. Through making descriptions interpretive and describing a phenomenon, the interpretive description design does not stop at pure description. It integrates association, relationships, and patterns of experiences through systematic analysis of a phenomenon and its inherently social,

political, and ideological complexes while maintaining variations in subjective experiences (Thompson Burdine et al., 2020; Thorne, 2016).

Indigenous peoples' in Canada have been the topic of copious amounts of research largely due to unethical research conducted on Indigenous peoples' and experienced many smash-and-grab data experiences (Kovach, 2021). Smith (2021) explains "the word itself, research, is probably one of the dirtiest words in the Indigenous world's vocabulary" (p. 1). It is essential to honor Indigenous methodologies while engaging in research with Indigenous peoples'. Indigenous methodologies co-exist alongside qualitative methodologies. The interpretive description design allows for the co-existing of Indigenous methodologies woven in throughout as ID is formed on the premise of the research question at hand and the human subjective experience (Thorne, 2016). The literature captures the historical colonial history of Indigenous peoples' in Canada, perspectives of nurses caring for Indigenous patients, nursing educators attempting to integrate Indigenous health needs into curricula, Indigenous peoples' current health status, and Indigenous patients' experiences of Western and Indigenous-focused health centers. First Nations peoples are best positioned to describe their experiences in receiving nursing care to meet their wholistic health needs. First Nations peoples' voices are absent when describing their experiences of receiving nursing care to meet their wholistic health needs.

### **Role of the Researcher**

In this interpretive description qualitative research study, my role as the researcher was to determine a research phenomenon through a gap in the literature,

develop a research proposal, and obtain IRB approval to investigate and analyze First Nation participants' experiences receiving nursing care to meet their wholistic health needs. As the primary researcher, I am the primary instrument throughout all aspects of this study. I must acknowledge myself through positionality and location while adhering to Western methodologies and attempting to integrate Indigenous methodologies into the research process.

I am of First Nation and settler heritage, which I acknowledge and honor as I learn my culture and learn to embrace Mino-Bimaadiziwin - The way of a good life and my role in reconciliation as someone with settler heritage. I am an Anishinaabe kwe belonging to Fort William First Nation, where I have lived on reserve since I was a young child and currently reside. My settler heritage on my mother's side brings a sprinkle of Italian, Ukrainian, Dutch, and Irish. I have the privilege of being able to live between both Western knowledge systems and Indigenous knowledge systems. I am a daughter, a sister, a cousin, an auntie, and a friend, but my most treasured title of all is being a mother and a partner.

Western titles privilege me by adding the following letter designations after my name: RN, MN, BScN, and PhD student. These letters after my name have not come easily, nor have my family and ancestors been afforded the same privilege. I acknowledge I am a novice researcher trying to adhere to Western methodologies while integrating Indigenous methods to the best of my current knowledge base. I am Makwa Clan "Bear clan," which involves Zoongide'ewin "Courage/Bravery" translates to "a state of having a strong heart". It involves having a strong heart, strength, integrity, and

ferocity for current and future generations. The essence of my PhD journey involves protecting and advocating for the current generation and future generations through my research aspirations. This dissertation topic comes from a place of purpose and passion. I do have direct access to the sample population as an insider and First Nations person (Kovach, 2021).

As a practicing nurse and nursing educator, I have witnessed Indigenous peoples' in practice present with unmet health needs while having the Western biomedical model pushed as the only option to address their health issues. I have witnessed racism and discrimination towards Indigenous patients from nurses and health care providers in the health care setting. I have witnessed nursing and health care curricula being delivered that are White-centered, colonial, prejudicial, racist, and intentionally or unintentionally dishonoring Indigenous knowledge and ways of being. As a nursing educator, I have worked with many relations who lack knowledge of Indigenous wholistic health needs, contributing to the struggle to meet accreditation standards and adequately integrate Indigenous health content into curricula.

Throughout my study, I applied the two-eyed seeing framework. The two-eyed seeing framework allows the researcher to integrate Indigenous and Western knowledge to weave between both worldviews (Wright et al., 2019). Roher et al. (2021) elaborate by saying that two-eyed seeing as a framework offers insight into understanding each knowledge system independently, which can only offer a partial understanding of the world, and both knowledge systems are needed to understand the world. I am conscious of my identity as an Indigenous person and settler person and my positionality as a

researcher and how this can potentially lead to bias in my study. I applied the two-eyed seeing framework in reflective journaling to reflect on my identities as I prepare for interviews, conduct interviews, analyze data, and disseminate results. I plan to use member checking with participants by sharing their transcripts with them after the interview to ensure their perspectives are accurate and reflect the stories they share.

By acknowledging and reflecting on my identity and positionality walking in two worlds as both an Anishinaabe and settler, nurse, and nursing educator, I can create a protected space for First Nation people to describe and share their stories of receiving nursing care to meet their wholistic health needs. I am the story listener being gifted the stories and I am the storyteller when I disseminate findings. Describing and learning from these gifts of stories can change how our First Nation relations receive nursing care and allow me to use my courage as Makwa Clan “Bear clan” to address the current state of nursing curricula and Indigenous health policy. The gift of stories shared by the participants contributed to providing culturally appropriate curricula in nursing education to prepare students for clinical practice and be used by nursing faculty as they develop and deliver innovative nursing curricula rooted in cultural safety.

### **Methodology**

The methodology section explores the process and rationale for selecting participants, the procedures for participant recruitment, sample size, data collection and procedure, and data analysis.

**Participant Selection Logic**

The inclusion criteria was any First Nation adult aged 18 years and older in Fort William First Nation who has received or accessed any form of nursing care in Canada in the last 2 years. Primary care providers and/or substitute decision-makers of Fort William First Nation's family members were eligible to share their stories on behalf of those unable to. Participants self-identify as First Nation, be status or non-status, and belong to Fort William First Nations community to be eligible for enrolment. First Nation participants must be able to read, write, and conduct the interview in English. Exclusion criteria would be not within the designated age period, not First Nations, not belonging to the Fort William First Nations community, and have not received nursing care for themselves or the person they have cared for in the last two years. Purposeful and snowball sampling was deployed to recruit participants.

**Participant Recruitment**

IRB approval was obtained (05-27-25-1169520) and Fort William First Nation Chief and Council approved the study prior to the recruitment of participants. The best sources for finding participants for this study was circulating recruitment flyers on social media and networking platforms. A copy of the recruitment flyer is found in Appendix A. Flyers was distributed publicly on social media platforms like Facebook, Instagram, The X, and LinkedIn. Once participants expressed interest via email or phone, a formal invitation outlining the study and an informed consent form was sent. Participants were informed via the email invitation that the local knowledge holder will be present during the interviews as noted on the consent form. Participants were informed that raw data and

data analysis will be shared with the chair, committee, and local knowledge holder with all identifying information removed on the consent form.

### **Sample Size**

Qualitative research has no set sample size (Patton, 2015). However, research must consider determining sample size to achieve saturation, which involves analyzing the “scope of the study, nature of the topic, quality of data, and the study design” (Gray & Grove, 2021; Mason, 2010). The study aims to recruit 8-12 participants, but the focus of qualitative research should not be sample size but rather saturation where new data does not lead to uncovered insights (Mason, 2010). Data saturation in qualitative research focuses on no new data being presented, and the data presented is redundant to previously collected data (Gray & Grove, 2021). Ravitch and Carl (2021) simplify this to attest that data saturation occurs when the researcher has reached the information threshold, and no new information is generated. When using interpretive description (ID) design, Thompson Burndine et al. (2020) explain that data saturation is not the benchmark for data collection. ID understands that there is infinite variation in subjective experiences, and the focus should be gathering a deeper understanding of the subjective experiences, including variations in perceptions of those experiences (Thompson Burndine et al., 2020). The proposed study used data saturation to ensure no new information was uncovered and redundancy was present. However, the study focused on a deeper interpretive understanding of the various subjective experiences of First Nations people.

### **Data Collection “A Gift of Hearing Stories”**

In Indigenous methodology, data is referred to as the logic of the gift, and data collection is “the gifting of another story to a researcher” (Kovach, 2021). Data was collected using semistructured interviews with a researcher-developed interview guide (Appendix A). Research yarning in Indigenous methodologies is semistructured interviews in Western methodology (Kovach, 2021). Research yarning gathers stories (data) through a relaxed and interactive purposeful conversation with a defined beginning and an end (Kovach, 2021).

#### ***Researcher-Developed Instrument***

The interview guide is located in Appendix B. Ravitch & Carl (2021) explain that interviews are person-centered as they allow careful attention to the interviewee’s experiences, opinions, feelings, and ideas. The interview guide was developed on the premise of recommendations by Patton (2015), Ravitch & Carl (2021), and Rubin & Rubin (2012). The core questions were developed based on Indigenous wholistic theory’s core concepts of physical, emotional, mental, and spiritual needs while integrating the interconnectedness of those domains to oneself, family, community environment, and relationships (Abolson, 2010; Moscou, 2022; Richard, 2011). The literature demonstrates current research related to discrimination, racism, and prejudice so questions related to that specific experience were purposely omitted as redundant to allow a heavy focus on wholistic health needs (Barbo & Alam, 2024; McLane et al., 2020; Sehgal et al., 2023). The interview guide was peer reviewed by the chair, committee, and local knowledge holder.

### *Semistructured Interviews “Research Yarning”*

Interviews were conducted in person or online on Zoom and audio recorded. Face-to-face interviews are highlighted as advantageous as they allow synchronous communication to provide social cues, no time delay between questions and answers, a good interview ambiance, and easy interview closing (Opdenakker, 2006). Online Zoom options were provided to participants who did not live in the geographical area to ensure no participants were intentionally prevented from being involved in the study due to geographical barriers. After recruiting participants, obtaining informed consent, and scheduling interviews, each interview began by self-locating myself as I have previously done above in the role of the researcher. Self-locating in the research process allows the participant to understand the researchers’ situation and motivations for completing the research (Kovach, 2021). I provided an opportunity for the local knowledge holder to introduce themselves and self-locate.

Interviews were audio recorded and transcribed. Halcomb and Davidson (2006) noted that accuracy with verbatim transcripts is paramount, and cross-checking between the original audio and transcribed interview must be done. I used Zoom (2023) for transcription and audio recording for in-person and online. A separate Zoom (2023) licensing account was secured for this dissertation to ensure participants’ integrity, confidentiality, and anonymity. Once the initial transcription was complete, I re-listened to the audio twice to check the transcription. I revisited my field notes to make any additional notes needed. Once I was satisfied that the transcript was accurate, I saved it within the participant folder label. The final saved interview was sent to participants to

view for accuracy before data analysis. Member checking with participants ensures trustworthiness through credibility and confirmability (Ratvich & Carl, 2021). It also aligns with recommendations from Kovach (2021) and Wilson (2008) for reciprocity for Indigenous participants.

I organized data by creating a separate password-protected folder in my password-protected laptop. I developed sub-folders within the folder labeled Participant One, Participant Two, and so on, with additional participants who received their assigned numbers. I created an audit trail in a Word document of all the steps involved in recruiting participants, obtaining informed consent, and scheduling the interviews, which was saved in the main folder. Each informed consent obtained was stored the respective participant folder, which is password-protected. The interview audio and written transcript was stored in each participant's folder as a Word document. A Word document labelled field notes was in each participant's folder. All identifying information was removed from all documents except for informed consent, which remained password protected. Participants were made aware in the initial informed consent that documents and data will remain stored for a period of five years and will then be permanently deleted.

### **Data Analysis “Learning From the Gift of Stories”**

Interpretive description design does not prescribe data analysis techniques. Thorne (2016) articulated that regardless of the data analysis approach chosen, researchers must be engulfed in their data, dwell on their data purposefully, and know their data. Thompson Burdine et al. (2021) explain that constant comparative analysis is a

flexible approach that responds to the purpose of the research. Constant comparative analysis is an analytical approach that stems from grounded theory to “compare every piece of data (an interview, a statement, a theme) with all the others that may be similar or different from it to theorize all relationships among the data” (Thorne, 2016, p. 168).

The data analysis approach followed the six steps of immersion, development, organization, condensing and reflecting, comparing and contrasting similar categories, and comparing and contrasting different categories (Thompson Burdine et al., 2021). I immersed myself in the transcribed Word documents, interviews, audio recordings, and field notes using a hands-on approach. This process involved reading, re-reading, and re-reading until I fully understood the story of my participant. As I immersed myself in the data, I began highlighting parts of the stories that stood out. Saldana (2021) adds that after the initial review, the researcher should do a personal debriefing self-reflection or reality check using an analytical memo. Indigenous methodologies identify the same approach to self-reflection, self-locating, and self-positioning before, during, and after yarning (Kovach, 2021). I developed a master thematic template and began organizing the data based on the template. Coding is an interpretive act and not precise (Saldana, 2021). When codes appear more than twice, they form a pattern in the data (Saldana, 2021). Saldana (2021) explains that codes are often revised with subsequent coding and can be grouped into categories according to defining attributes. Categories are emerging factors from the dataset itself (Singh & Thirsk, 2022).

## **Issues of Trustworthiness**

Rigor in qualitative research is achieved through trustworthiness in integrating the standards of credibility, dependability, transferability, and confirmability throughout the study's purpose, design, data collection, and data analysis (Burkholder et al., 2020; Ravitch & Carl, 2021; Singh & Thirsk, 2022). Ravitch and Carl (2021) explain that trustworthiness or quality can never be fully met but is a process or goal throughout the study.

### **Credibility**

Credibility refers to internal validity in qualitative research and ensures that the data is accurate, valid, and sound (Ravitch & Carl, 2021; Singh & Thirsk, 2022).

Credibility focuses on the research design and supporting codes, categories, and themes with direct quotes from the data (Ravitch & Carl, 2021). Credibility can be improved through member checking, presenting thick descriptions, and using peer debriefers. For this study, I used member checking with my participants and peer debriefing with my chair, committee, and local knowledge holder. In my data analysis, I integrated thick descriptions directly from participant interviews to honor and share their story.

Respecting First Nations' stories and capturing their story accurately is vital to the principles of respect and relationality of Indigenous research methods (Kovack, 2021; Wilson, 2008)

### **Transferability**

Transferability is not the ability to generalize the findings to another setting but how the study can be transferred to a broader setting, group, or context while maintaining

its contextual richness (Ravitch & Carl., 2021; Stenfors et al., 2020). Providing thick descriptions of data in the contextual richness of the analysis can improve the ability to transfer it to other broad contexts (Ravitch & Carl, 2021). Thick descriptions alongside the data analysis support contextual richness while understanding other First Nations in Canada's wholistic health needs. It is important to note that all First Nations people are different. Their language, cultural beliefs, cultural practices, and knowledge can differ (Chiefs of Ontario, n.d.-b)

### **Dependability**

Dependability refers to the consistency and stability of the data and its analysis (Ravitch & Carl, 2021; Stenfors et al., 2020). It ensures that the appropriate research design, core constructs, data collection, and data analysis have supporting rationale (Ravitch & Carl, 2021). The research question aligns with interpretive description design as it focuses on the lived experiences and perspectives of the participants or similar lived experiences of participants (Gray & Grove, 2021; Patton, 2015; Singh & Thirsk, 2022). The core constructs of the Indigenous wholistic theory align with the research question of the wholistic health needs, which provided the foundation of the interview guide alongside the two-eyed seeing framework. The data collection from participants had specific inclusion and exclusion criteria to purposefully sample those Fort William First Nation participants who have received nursing care.

### **Confirmability**

Confirmability involves the researcher shaping the data and the link between descriptions of findings and the actual quoted data (Stahl & King, 2020; Stenfors et al.,

2020). Member checking, audit trails, and reflexivity are ways to improve confirmability (Ravitch & Carl, 2021). Member checking was completed with participants once transcripts were transcribed. Electronic copies of the transcripts were emailed back to participants to review for accuracy. Audit trails from the beginning to the end of the data collection was maintained. Positionality and reflexivity are crucial to ensure bias or prejudice is not integrated into the study (Ravitch & Carl, 2021). Analytical memos and reflective journaling were completed to aid this process (Ravitch & Carl, 2021). Using the two-eyed seeing framework, I maintained a reflective journal before and after interviews to reflect on biases, my experiences as an Indigenous person and as a settler, my experiences as a nurse and a nursing educator, and my experiences as a patient. Kovach (2021) adds that integrating self-locating, self-positioning, and self-reflection is crucial to honoring and integrating Indigenous methodologies.

### **Ethical Procedures**

A vulnerable population, access to participants, data sharing and participant privacy, informed consent, minimal risks, and honorariums are ethical challenges to consider for the proposed study. Indigenous peoples' are classified as a vulnerable population to conduct research with, as outlined in Chapter Nine of the TCPS2 (2022) involving the First Nation, Inuit, and Metis people of Canada (Government of Canada, n.d.-h). The TCPS2 (2022) must be integrated into the entire research process as the population of focus is First Nation people, who are a vulnerable population, and there are unique cultural considerations that must be considered at each stage of the research process. Indigenous peoples' have experienced exploitative, data and grab situations and

unethical research conducted on them (Bull et al., 2020; Loppie & Wien, 2022; Morisano et al., 2024). There is a need to ensure that Indigenous participants are right holders with sovereignty in the research process and that the research process is collaborative with the Indigenous participants and not exploitative.

Data must be shared with the Indigenous participants and the Indigenous community, adhering to the First Nation Principles of OCAP® of ownership, control, access, and possession (First Nations Information Governance Centre, 2017). Ownership relates to the relationship between the Indigenous community and its knowledge and information, outlining that the community owns its information (First Nations Information Governance Centre, 2017). Control refers to the Indigenous community having control over the research process, including reviewing all aspects (First Nations Information Governance Centre, 2017). Access refers to the Indigenous community being able to access the data regardless of where it is currently located (First Nations Information Governance Centre, 2017). Possession is the assertion that data ownership can be maintained (First Nations Information Governance Centre, 2017). Participants were informed that my chair, committee member, and the local knowledge holder had access to the raw data and data analysis but are bound by these ethical considerations. All participant identifying information was removed and concealed. A copy of the final dissertation will be given to the participants and the Fort William First Nation Chief and Council.

Given these principles, I was particularly careful to protect the privacy of my participants, as the results of the study will be shared with the First Nation community in

adhering to the principles of OCAP. The transcripts and recordings were saved in a password-protected folder on a personal password-protected computer. All participant-identifying information about the name or any other demographical data that can give rise to the participant's identity was removed to promote confidentiality. Furthermore, all participants' identifying data was removed at the end of the interview, and participants were assigned a number. The location of study was the community of Fort William First Nation (FWFN). FWFN Chief and Council approval was obtained following a distribution of a council briefing note and an in person presentation by the researcher and knowledge holder. All ethical considerations of unmasking the community's name were discussed. The FWFN Chief and Council wanted to be unmasked and identified in the study aligning with their cultural beliefs of honoring their unique cultural knowledge. Participants were made aware the community of Fort William First Nation was identified in the study as noted on the informed consent form.

The recruitment site is a singular First Nations Community of Fort William First Nation, Ontario. This is recommended by the Chiefs of Ontario (n.d.) to ensure the data generated is not low quality grouping many different First Nations cultural knowledge, beliefs, and ways of knowing together. Each First Nation has distinct cultural knowledge, beliefs, and ways of knowing together (Chiefs of Ontario, n.d.). FWFN is only granting permission to conduct research in their community aligning with best practices of conducting research with First Nation Communities (First Nations Information Governance Centre, 2017; Government of Canada, n.d.-h). The entire research folder will be deleted in the following five years to ensure this study can be completed. These steps

align with the recommendations from Walden University's Office of Research and Compliance Institutional Review Board (IRB) (n.d.) requirements for selecting participants related to storing project data and de-identifying data.

The recruitment of participants did not begin until IRB approval was obtained (05-27-25-1169520) and the Fort William First Nation's governance of Chief and Council approval was given. Informed consent must be obtained from the Indigenous community and the participants (Fitzpatrick et al., 2016). Informed consent was obtained via email before scheduling interviews. Informed consent was emailed to participants, which outlined the detailed contacts for the Walden University IRB, their rights in the research process, length of time expected for the interview, optional local knowledge holder support available during and after the interview, data sharing and privacy outlined above, and the ability to terminate the interview or withdrawal consent to share their stories at any point in time. All data was kept in a password-protected laptop and folder for five years and will then be permanently deleted.

Minimal risks are present when asking First Nations people to share their experiences, which can be positive or negative. The literature identifies Indigenous peoples' reporting discrimination, racism, and prejudice by health care providers (Kitching et al., 2020). First Nation's people recounting experiences of receiving care may evoke traumatic or negative emotions. To address this concern, a local First Nations knowledge holder from the community is integrated into the study (Datta, 2018). A First Nation knowledge holder was used as needed throughout the research process to act as an Indigenous knowledge holder and support the researcher and participants in addressing

negative emotions or responses that may follow throughout the research process (Datta, 2019).

The knowledge holder Margie Bannon is identified and respected by the community as having cultural knowledge, experience with Western research, and a prominent social worker with a master's degree. The knowledge holder role in this dissertation is to ensure the research process respects the cultural norms and cultural knowledge of FWFN. Integrating a knowledge holder into the research process is identified in Article 9.15 of the Tri-Council Policy Statement (TCPS 2) (2022) as “researchers should engage the community in identifying Elders or other recognized Knowledge Holders to participate in the design and execution of research, and the interpretation of findings in the context of cultural norms and traditional knowledge.” (Government of Canada, n.d.-h). Integrating a knowledge holder from the community into the research process is best practice and should be done with every single research study involving First Nation, Inuit, or Metis people in Canada (Bull et al., 2020; Datta, 2018; (Government of Canada, n.d.-h; Loppie & Wien, 2022; Morisano et al., 2024)

In honoring the local knowledge holder and participants sharing their experiences and stories in this research study, tobacco was offered at the commencement of the interview, and an honorarium was provided the local knowledge holder and the participants. The participants received a \$30 Walmart gift card.

### **Summary**

This study aimed to describe First Nations peoples in Northern Ontario's experiences when receiving nursing care to meet their wholistic health needs. Through

the qualitative study using interpretive description design, the research question asked was what the experiences of First Nation peoples in Northern Ontario are when receiving nursing care to meet their wholistic health needs. The purpose, research question, and methodology align as the focus is to respond to the gap in the literature of not knowing what First Nations experiences are in receiving nursing care to meet their wholistic health needs. ID focuses on practical and patient outcomes through describing and interpreting data (Thorne, 2016; Wright et al., 2019).

Indigenous methodologies are honored alongside Western methodologies throughout this research process. First Nation participants who received nursing care in the last two years were purposely or snowball recruited through social media flyers to participate in the semistructured interviews. Data analysis followed the constant comparative method and integrated strategies for credibility, dependability, transferability, and confirmability. Ethical concerns were explored with strategies to mitigate them. In Chapter 4, I will discuss the study setting, demographics, data collection, data analysis, evidence of trustworthiness, and study results.

## Chapter 4: Results

The purpose of this qualitative interpretive description study was to describe First Nations people's experiences of receiving nursing care to meet their wholistic health needs. The research question of this study was the following: What are the experiences of First Nations people in Northern Ontario when receiving nursing care to meet their wholistic health needs? The study was guided by the Indigenous wholistic theory (Abolson, 2010) and the two-eyed seeing framework (Bartlett et al., 2012; Rieger et al., 2020; Roher et al., 2021). This chapter presents the setting in which the study took place, the demographics of the participants, the data collection and data analysis approaches used, evidence of trustworthiness, and the results of the study.

### **Setting**

The study took place in the community of Fort William First Nation, Ontario. Fort William First Nation is an Ojibway First Nation Community on the western end of Lake Superior and a signatory body to the Robinson Superior Treaty of 1850 (Fort William First Nation, n.d.). The Chief and Council of Fort William First Nation approved the study on May 1, 2025, and requested that the site be unmasked and named in alignment with their cultural beliefs of honoring their unique cultural knowledge. The recruitment of participants from Fort William First Nation began and lasted approximately 3 months. The recruitment flyer was posted on various Fort William First Nation community Facebooks and distributed by Fort William First Nation's communication officer to their public Facebook page and private member messaging communication software of Hawk Communication. Interviews were conducted in person and via Zoom, based on the

participants' preference to ensure that no participant was intentionally excluded from the study due to geographical location or personal preference. Interviews were recorded using Zoom's audio-only software with all identifying information removed from the transcripts to maintain the confidentiality of the participants.

### **Demographics**

Participants were asked a series of demographic questions to ensure the sample was heterogeneous and all members belonged to Fort William First Nation, aligning with the inclusion criteria. A summary of the demographic data is presented in Table 1. The sample represented equal numbers of on- and off-reserve members and a balanced portion of three participants under 50 years of age and three participants over 50 years of age. The participants were mostly female, with one male participant, and most shared their story as recipients of nursing care, with one participant speaking as a caregiver of a relative who received nursing care.

**Table 1**

*Demographic Data of Participants*

Demographic	Group	Number
Gender	Female	5
	Male	1
Age	18–30	2
	31–50	1
	51–64	2
	65+	1
Care status	Recipient of care	5
	Caregiver	1
Member status	On reserve	3
	Off reserve	3

### **Data Collection: A Gift of Hearing Stories**

Participants expressed interest in the study via email. They were screened for eligibility with the inclusion criteria in email communications. Once eligibility was determined, participants were emailed the informed consent. When informed consent was established with the phrase “I consent”, participants were given various interview times to choose from, the option to conduct the interview with or without the knowledge holder present, and the choice of interview method (in-person or via Zoom). Six participants were interviewed using a semistructured interview approach, employing the interview guide provided in Appendix B.

The interviews began on June 16<sup>th</sup>, 2025, and concluded on September 15<sup>th</sup>, 2025. The interviews varied in length from 33 minutes to 2 hours and eight minutes. The length of interview transcripts ranged from 19 pages to 66 pages. These variations in interview lengths corresponded to the pace at which the participant shared their unique story, the length of that story, and their responses to the interview questions. A table was used to track participants’ expression of interest, eligibility approval, obtaining informed consent, date of interview, and length of interview. All interviews, regardless of in-person or on Zoom, were audio-recorded using Zoom software. After the interviews were conducted, each audio-recorded interview was cross-referenced three times against the transcript to ensure accuracy. After the sixth interview, data saturation and thick descriptions of the participants’ subjective experiences were established, and no further interviews were conducted.

### **Data Analysis: “Learning From the Gift of Stories”**

Interpretive description design does not prescribe data analysis techniques; instead, it focuses on describing the data and interpreting the patterns, relationships, and interactions within it (Thorne, 2016; Wright, 2019). In Chapter 3, the data analysis plan of using a general constant comparative analysis was explained. However, during early stages of data analysis, it became evident that the data (participants’ stories) did not align with constant comparative analysis. It became apparent to me, and was confirmed by my committee methodologist, that the analysis would benefit from Saldana’s nuanced approach to capture the complexity of the data and incorporate for researcher subjectivity and reflection. As a result, the decision was made to switch from constant comparative analysis to thematic analysis using Saldana’s (2021) approach.

Thematic analysis, using Saldana’s (2021) techniques involves familiarization with the data, identifying key words, code and category formation, theme development, defining and naming themes, and determining the final themes. Saldana (2021) explains that a code stands on its own and is a symbol or translation of the data itself, generated through the researcher’s interpretation. When codes appear more than twice, they are a pattern in the data (Saldana, 2021). Saldana (2021) further explains that codes are often revised through subsequent coding procedures and that codes can be grouped into categories according to defining attributes. Categories are emerging factors from the dataset itself (Singh & Thirsk, 2022). Themes emerge from the patterns of the categories and bring meaning to the whole (Christou, 2022). This revised method aligns with the data analysis, the purpose of the study, and the guiding research question.

Data was analyzed manually using transcripts of interviews, my reflective memos, and field notes composed shortly after each interview. Each interview was read twice to understand the participant's story fully prior to initiating individual analyses. Before coding the story and highlighting parts that stood out, I completed a personal debrief to reflect on any personal biases, emotions, and further, to ensure my identity as an Indigenous person, a settler, a nursing educator, and a nurse did not guide my coding. The third reading of the interviews involved highlighting parts of the story that yielded significant statements in response to the research questions. A fourth reading was conducted to verify that all significant statements had been identified. A master template in Microsoft Word was developed to ensure consistent coding of participants' stories.

A total of 21 codes remained at the end of the third cycle. Categories were developed from the codes with a resulting seven categories that emerged from the stories of the participants. Three themes were developed from the categories that explained the phenomenon of the study. These themes were "Negative Nursing Experiences Resulting in Unmet Needs, Nursing Practice and Nursing Education Need Change, and A Need to Honor and Integrate First Nation Beliefs. In Table 2, a copy of the summary of codes, categories, and themes that emerged from the stories of the participants.

**Table 2***Summary of Themes, Categories, and Codes*

Theme	Category	Code
Negative nursing experiences resulting in unmet needs	Racism	Aggressive
	Equality and equity	Neglect
	Identity, racism, prejudice	Dismissal
	Unmet health needs	Delay in receiving treatment
	Lack of care	Unmet cultural needs
	Delay in seeking treatment	
	Lack of advocacy	
	Being an advocate	
Nursing practice and nursing education need change	Needing an advocate	
	Western approach	
	Western-led facilities and approaches	
	Physical focus	
	Practice change needed	
	Improving nursing care	
	Knowledge deficits	
A need to honor and integrate First Nations beliefs	Wholistic health	Met needs
	Wholeness or wholistic	Traditions
	Imbalances	
	Integrating First Nation beliefs	
	Cultural practices	
	Indigenous-led facilities and approaches	

### **Evidence of Trustworthiness**

Rigor was achieved in this qualitative study through credibility, dependability, transferability, and confirmability (Burkholder et al., 2020; Ravitch & Carl, 2021; Singh & Thirsk, 2022).

### **Credibility**

Credibility refers to internal validity in qualitative research and ensures that the data is accurate, valid, and reliable (Ravitch & Carl, 2021; Singh & Thirsk, 2022).

Credibility focuses on the research design and supporting codes, categories, and themes with direct quotes from the data (Ravitch & Carl, 2021). Credibility can be improved through member checking, presenting thick descriptions, and using peer debriefers. For this study, I used member checking with my participants and peer debriefing with my chair, committee, and local knowledge holder. In my data analysis, I integrated thick descriptions directly from participant interviews to honor and share their story.

Respecting First Nations' stories and capturing their story accurately is vital to the principles of respect and relationality of Indigenous research methods (Kovack, 2021; Wilson, 2008)

Member rechecking, peer debriefing, and thick descriptions were methods used in this study to improve credibility (Ravitch & Carl, 2021; Singh & Thirsk, 2022). Member checking was used with each participant. Each participant was emailed a copy of their written transcript to review for accuracy of their story. Peer debriefing was conducted with my chair, committee, and local knowledge holder throughout the interview process and data analysis. Thick descriptions of each participant's story were included in the codes and discussed in the results of this chapter.

### **Transferability**

As mentioned in chapter three, all First Nations people in Canada have very different languages, cultural beliefs, practices, and knowledge (Chiefs of Ontario, n.d.-b). The findings from the participants who belong to FWFN may be different than other first nation communities as it relates to cultural practices, traditions, and beliefs. However, this study presented thick descriptions of data, which can improve the contextual richness

of the analysis (Ravitch & Carl, 2021). A similar study can be conducted in other First Nation communities to analyze their unique nursing experiences to determine if similar experiences and stories are shared.

### **Dependability**

Dependability refers to the consistency and stability of the data and its analysis (Ravitch & Carl, 2021; Stenfors et al., 2020). The research question aligned with an interpretive description design, chosen and focused on the population of First Nation people. The data collection from participants had specific inclusion and exclusion criteria to purposefully sample those from Fort William First Nation who had received nursing care. Each participant was carefully screened to ensure eligibility in the study. Although the data analysis method did change during data analysis, each step of data analysis was clearly and concisely described. Each interview was conducted using the interview guide in Appendix B. The interview guide was a research-developed instrument derived from the Indigenous wholistic theory and the Two-eyed seeing approach.

### **Confirmability**

Confirmability was maintained in the study through member checking, audit trails, and reflexivity (Ravitch & Carl, 2021). Member checking was completed with participants once transcripts were transcribed. Electronic copies of the transcripts were emailed back to participants to review for accuracy. Audit trails from the beginning to the end of the data collection was maintained through identifying eligibility dates, informed consent dates, and interview dates, and lengths of interviews for participants. Using the two-eyed seeing framework, I maintained a reflective journal before and after interviews

to reflect on biases, my experiences as an Indigenous person and as a settler, my experiences as a nurse and a nursing educator, and my experiences as a patient. After the first cycle of coding, I completed a reflective journal of self-locating, self-positioning, and self-reflection to ensure that my biases and experiences were not shaping my coding (Kovach, 2021). Multiple data analysis techniques were employed.

### **Results**

This study aimed to answer the research questions of “what are the experiences of First Nation people’s in Northern Ontario when receiving nursing care to meet their holistic health needs?” Through learning from the gift of stories in data analysis (Kovach, 2021), three major themes emerged from the participants stories noted in Table 2 above of negative nursing experiences resulting in unmet needs, nursing practice and nursing education needs change, and a need to honor and integrate First Nations beliefs. The three themes were:

- negative nursing experiences resulting in unmet needs
- nursing practice and nursing education needs change
- a need to honor and integrate First Nations beliefs

#### **Theme 1: Negative Nursing Experiences Resulting in Unmet Needs**

The theme of negative nursing experiences resulting in unmet needs derives from participants sharing their stories labelled in categories of racism, unmet health needs, and advocacy. The codes in these three categories are equality and equity, identity, racism, and prejudice, aggressive, neglect, dismissal, lack of care, delay in seeking treatment,

delay in receiving treatment, unmet cultural needs, being an advocate, and needing an advocate.

### ***Equality and Equity***

Participants shared that their nursing experiences left them feeling like nurses do not consider First Nation people's as equals and that First Nation people's have different needs than the rest of the population. Participant two shared "not enough people consider natives equal... I would hope they treat them [First Nations people] as equals. But I don't see that's the case." Participant one felt that nurses were "categorizing them [First Nations people] all the same." Participant three echoed that nurses should know "that we're humans. We're not less than. We're equal. We're beautiful. We're worthy. We're simple. We don't need all these fancy terminologies. Let's just keep it simple. We're kind. We're loving." Participant six felt that First Nation people's have unique and different needs "you have my status card on file, that should immediately trigger an additional set of questions that are asked to make sure that you're, like, speaking to those additional needs that come along with being Indigenous. We have different needs."

### ***Identity, Racism, and Prejudice***

Participants were not asked any questions about racism or prejudice directly in the interview guide. It became very apparent through almost all the interviews' participants felt their identity as First Nations person led to racism and prejudice by nurses. Participant five identified their address on their health card and chart lead to racism, "my address is Fort William First Nation, so they know. I really felt like they were pushing me around because we're Indians." Participant three shared a similar acknowledgement of

their health card address that is front facing for nursing staff, “so when I’m going to emerge and you’re sending my family member home, the first thing I think of is the address on their health card.” Participant six echoed a similar experience:

I know I present as Indigenous, but I know that they see I have a status card on file and I know I’m being judged by that, you know? I feel racial profiled by them. It’s, like, all the racial biases that have come along with it. Those racial tones and biases are so loud.

Many participants felt they received prejudicial treatment by the nurses.

Participant three explained “I feel like, oh, it’s just another Indian like. Let’s just poke at them and see what happens. They look at one native, and then that one native paint all other natives that.” Whereas participant five identified “we’re not all drug addicts or we’re not all at the hospital to get medication...because they tend to sway that way towards that...fit us all into one category. It’s always been like that.”

### *Aggressive*

Participants shared their nursing experiences as feeling like the nurses were unnecessarily aggressive, rough, or standoffish when receiving nursing care. Participant three shared their experience as a caregiver for a family member and reflects on the nurse “just started ripping because they had 2 IVs in. Yeah, she just started ripping tape off and uhm like changing stuff. But like the way she came in the room. Like, she was being really aggressive. I felt very threatened.” Participant four felt during their nursing experience “nurses [were] being unnecessarily rough when they’re inserting the IV or palpating my insides a little bit to uhm rough. It’s all of those like little things that happen

over and over that make experiences feel torturous and it chips away at your sense of dignity.” Participant six felt like the nurse was “being standoffish towards me.”

### *Neglect*

Participants shared aspects of their nursing experience which left them feeling neglected from receiving necessities like walking and showering, responding to call bells, not being heard, and feeling invisible. Participant three shared their family member did not have a shower in seven days and was not refused to be walked by nursing staff “it was day seven. They never showered my family member...refused to walk my family member.” Participant two recounted their experience of having chest pain and having to ring the call bell twice with no response:

Because when you pull that cord you expect results. At least I do. Anyway, I don't know if anybody else pulls it just for the hell of it. I don't. If I pull it, I mean it. I know nurses are busy, but when you pull that cord twice, that's terrible.

Participant four expressed their nursing experience as “feeling completely invisible. It's not being addressed for hours, not understanding what's going on, especially when you're when you're in physical pain.”

### *Dismissal*

Participants shared experiences of nurses being dismissive to their complaints, feelings of being invisible, and having a negative consequence because of these experiences. Participant four shared if “the diagnostics don't point to a clear diagnosis, then you're out the door. And it wasn't just like a feeling of being dismissed or invisible. It's a reality.” Participant six explained that a nurse was “so dismissive, she was so

dismissive...that's what it is when you close the book and before I've even spoken."

Participant three shared their experience as a caregiver identifying their family member waited "over 33 hours that we were in ER before they finally got admitted, and then, once they were admitted it was again dismissed." Participant three went on to share that had their family member not been dismissed so quickly, the bacteria could have been identified sooner:

It went through the fracture in the eye, and the second visit, when I had to fight that doctor to get a scan of their head, you could see the fracture in the face, and you could see the gases already starting behind the eye so it could have been nipped in the butt. The second visit, and they didn't do it. And then not only that when they admitted them, and they made them wait 2, 3 days for an MRI.

### ***Lack of Care***

Participants felt that nurses did not show any care during their nursing experiences. Participant four shared their nursing experience as constantly:

Having to repeat yourself over and over, explaining that your symptoms are chronic, and then being told that it's probably just a stomach bug going around. Things like that are very harmful, you know. I know what it feels like when care is holistic, and I know what it feels like when it's not. And that contrast has shown me how essential, culturally rooted and relationship-based nursing care is to true healing. Without it even basic care can feel harmful.

Participant three shared their experience as a caregiver for a family member expressing that they felt like nurses had "lots of negativity." Participant three explained

further that the nurse “And I said, and how is that my family members fault? I’m like, have some care, care and compassion like you’re over here... You’re not telling them when you’re touching them or what you’re doing. You’re just doing whatever you please,”

### ***Delay in Seeking Treatment***

Participants recounted their nursing experiences resulted in them delaying seeking nursing treatment. Participant four shared:

When you’re used to being treated by people who don’t understand trauma or cultural context and sensitivity [of First Nations people], it’s easy to just stop seeking care altogether...having gone and felt like, unheard and unseen somewhere, such as our Western-led institution. Yeah, I think like it renders you feeling a little bit like you’re not worth going, or as if what you’re going in for is, you know, minute, not worthy of being treated.

Participant four elaborated to say that that the negative experiences resulted in “putting off appointments or avoiding the health care system entirely, which I’ve done in the past to avoid those uncomfortable or even harmful experiences.” Participant three felt similar to participant four in expressing “I just think about all our people, even myself. I’ve done it. I don’t want to go to the hospital, so I sit at home and I’ll wait and wait.”

### ***Delay in Receiving Treatment***

Participants shared experiences where they were not responded to and did not receive timely and appropriate care similarly to the code of dismissal. Participant two expressed “I was in the hallway quite a bit” when seeking care in the emergency room.

Participant four echoed a similar experience “you’re moved from a bed to the hallway.”

Participant six asked for treatment options “it was something I portrayed to her [the nurse], it was not something that she addressed.”

### ***Unmet Cultural Needs***

Every participant shared nursing experience where they were not asked about their culture, cultural needs, or traditional medicine use as a First Nations person.

Participant one and two identified they were not asked about their culture at all during their nursing experiences. Participant four explained “I was never asked about traditional medicine use or ceremony.” Participant five recounts:

I was never offered any type of Indigenous service. They never really asked me...do you need a medicine man to come in before your surgery...do you want a someone here to smudge with you? Or do you need smudging or do you need someone to talk to you...any of our cultural stuff that was never offered... they certainly didn’t meet me wholistically in an indigenous fashion.

Participant six felt very similar:

They have a bunch of medicines; it’s like they’re for show. You’re just, like, trying to check, like, take off a little checkbox. That’s how I feel, like, with them, like, just having these, like, the sage and tobacco sweetgrass all just sitting there.

It’s like, you never even offer it to, like, anyone who needs it.

### ***Being an Advocate***

Many participants shared nursing experiences of having to advocate for their own care. Participant five “I don’t allow anybody to treat me badly.... I am an educated

person, and I, you know, and I also ask a lot of questions about my health care.”

Participant three expressed:

I never shut my mouth that whole entire time...I had to advocate for my family member to stay there longer. I had to keep going, because if I didn't fight for my family member, and I just took them home, and my family member would have died.

Participant six shared “I have a voice, and I can use it, but...lots of people, lots of people from our community or other communities don't have a voice.”

### *Needing an Advocate*

Contrarily to being an advocate, participant four identified in their nursing experience they needed someone to advocate for them:

When I access health care oftentimes, especially at somewhere like the Western-led facility, I find myself very anxious, unable to speak for myself. So having someone that's able to advocate for me. Not speak for me but help convey what I'm trying to say or explain, and you know, anxiety on top of pain on top of what whatever else I think it does make having those discussions about what's going on physically all the more difficult.

### **Theme 2: Nursing Practice and Nursing Education Needs Change**

The second theme of nursing practice and nursing education needs change illuminated through categories of Western approach and change needed for nursing which were identified through the codes of Western-led facilities and approaches and experiences, the physical focus, improving nursing care, and knowledge deficits.

### *Western-led Facilities and Approaches*

Participants recounted their nursing experiences at Western facilities as being disconnected from wholistic care and a quick fix approach. Participant four explained “he Western care facility outside of my regular provider...felt like completely disconnected from wholistic care...it’s always been quick, quick, fix quick solution physically.”

Participant six shared “Western ideologies just have this power trip, like, it’s a power thing...Western health care in general probably considers spiritual health less, but yes, nursing care in general probably doesn’t even really consider mental health from my experience.”

### *Physical Focus*

Many participants shared similar experiences of nursing care that only focused on the physical domain of health. Participant one shared “it was definitely focused on the physical.” Participant six echoed a similar nursing experience of:

Just treating the medical issues at hand. How Western medicine works, you don’t do that. You don’t go over everything at once. You just, like, you come in when you have a single problem, and then you find a single solution, and then you get out

Participant four acknowledges nurses’ challenging workloads but still felt there was too heavy focus on physical symptoms “you can tell when nurses are on a time crunch...I do understand. But [they] definitely just focus on that physical treatment of symptoms.”

### *Improving Nursing Care*

Every participant shared an aspect of their story that could have improved their nursing experience and the care they received. Participant six expressed:

If you have record of the fact that I have a status card, then there should have been additional questions that, like, these people are asking to have us feel more comfortable and safe... feel like you at least understand what our needs are in the first place. At my age, I think they could ask, like, if I am engaged in my culture, you know? If I've ever been to my community...it would have to touch on your cultural health, like, because it's actually big part of your health.

Participant one highlighted a need to “knowing fully all the services that they have to offer and how it could be like jointly connected.” Participant three echoed the same as participant one with a desire for:

Knowledge of resources accessible to me as an Indigenous person. And what those resources are, you know the goals and aims, and what they're able to provide, and then asking me if I'm wanting to access those resources, so providing that that pathway, you know, it's about ease and comfort and just offering.

Participant five identified:

It's all about wholisticness for the Indigenous woman, not just the woman for the man, too involved for the whole family involved, that that may be something they might need to look at as close as indigenous families are there's always lots of people, and you know, I know Western facility has restrictions, but I mean man,

there's sometimes there's lots of family...Fort William when we got somebody up in ICU...there's hundreds of people going in and out of there, you know.

***Knowledge Deficits***

Many participants highlighted knowledge deficits of nurses as it relates to understand First Nation people's. Participant one highlighted nurses needing to:

Understand the importance of family. And when something does happen in a community, how it affects so many people, and it might be because we live all so close together, and we're all connected that my cousin is just important, as my sister like, you know, like you're when you're raised like that, or my, you know my friend is just as important as my family, because we grew up together right.

Participant four highlighted the need for nurses to know:

There needs to be a deeper understanding on connection to community and family and understanding that health isn't just individual. It's very much...what's the work...I'm just gonna say like connected. But when I had mentioned like, if my community or my family is hurting, I'm very much hurting...It's just understanding history, triggers, communication techniques, you know. Sometimes it's all about speaking softly or not making direct eye contact, understanding what your client might perceive, as you know, aggressive or hostile or insensitive.

Understanding First Nations history was highlighted by participant four, participant one, and participant three. Participant four explained nurses need to "learn about the history of Indigenous peoples' in Canada and the history of health care for Indigenous peoples' in Canada, uhm...understanding why there might be some

hesitancy.” Participant one highlighted nurses need to “understand why we are where they are, where they came from and thinking about like...what happened to previous... it’s almost like intergenerational why, somebody is the way they are...thinking about that whole back to Residential Schools and that.” Participant three shared nurses need:

Cultural sensitivity like to be aware of the history. And why First Nations people’s are the way we are. Why, we struggle with the things that we struggle. Yeah, maybe 10 years ago, maybe 25 years ago I was flagged for opiate addiction. I overcame that addiction, and when I come to the ER I’m not seeking medication like I actually want help.

### **Theme 3: A Need to Honor and Integrate First Nations Beliefs**

The third theme highlighted a need to honor and integrate First Nation beliefs into nursing care experiences. The third theme encompasses categories of wholistic health and integrating First Nation beliefs explained through the codes of wholeness or wholistic, imbalances, cultural practices, traditions, Indigenous-led facilities and approaches, and met health needs.

#### ***Wholeness or Wholistic***

Participants shared what wholeness and wholistic meant for them as it relates to receiving nursing care. Participant four shared:

Wholistic health would be being cared for as a whole person, so not just physically, but also taking into account emotionally, mentally, spiritually, culturally, wholistically suggests all encompassing. It’s about finding balance and being supported in all areas of my life. A big part of my wholistic health is my

sense of belonging. So, feeling connected to my identity, my community, and the land. As an Indigenous person, I'm still in the process of discovering who I truly am, after generations of attempts to erase our culture, our language, and our individuality. So, for me, wholistic care means not only treating that illness, but also nurturing that journey of reconnection to self and ancestors, community, and spirit.

Participant three explained a similar meaning adding "I think of our 7 grandfather teachings along with the medicine wheel and trying to find balance and the best of both worlds...wholistic healing, traditional medicines, elders like having elders present, ceremonies so like with the land offerings...sweats...tobacco offerings."

### ***Imbalances***

Participants identified imbalances in their wholistic being when seeking and receiving nursing care. Participant one, four, and five identified a link between physical and mental domains of health. Participant one noted "it started up physical, and it turned into like mental. It feels like a mental breakdown." Participant four explained:

If I'm not feeling well mentally, it's going to manifest physically a lot of like physical symptoms, whether it be poor, poor sleep, loss of appetite like gi symptoms, or if I'm like reverse feeling physically unwell, it's affecting me mentally. It's just I feel like they all work in harmony.

Participant five shared "physically remember not being able to move when both my knees were terrible and not having that physical health was bad on my mental health."

Participant three shared imbalances can affect all First Nations people according to First Nations beliefs:

Everything has a spirit, everything is alive. So, when I think of this infection and like this illness, I look at it as like a negative kind of being. Uhm, so I just want to like, acknowledge it, respect it and like, be done with it, like just because I've seen how fast it ate out my family member.

### ***Cultural Practices***

Participants highlighted there are opportunities to integrate First Nations cultural practices into nursing care. Participant four explained nurses should be “offering both like a Western treatment option, like medication or therapy referrals, but also encouraged that I see an elder or a traditional healing liaison.” Participant five shared a similar desire “I'm not opposed to Western medicine, and I'm not opposed to Anishinaabe medicine, so I'd probably want to try both. So, like Anishinaabe medicine man. I wanted to stop the Western medicine for a while and try bear grease.” Participant three recounted their experience with their family member and using traditional cultural practices and medicines:

We had the sage in the ICU and cedar and bear grease...I have bear root in my house. And that's a traditional anxiety medication. I would like, smell it, eat it I never, ever drank it. But yeah, I would even just like let it sit under my tongue.

### ***Traditions***

Participants shared a desire to practice cultural traditions when receiving nursing care. Participant three advocated a need to

Trying to find a balance in medicines...there's more ways than just zhaaganaash. And when I say zhaaganaash, I mean, like White man's way. And to be open minded and optimistic, and or to have an open mind about other healing methods and practices. And the different dynamics within families. This like to be mindful about, too.

Participant one and five highlighted the need to be able to use traditional medicines when receiving nursing care. Participant one "anti-inflammatory properties... obviously cedar. But then you have Ginger...cedar tea and ginger." Participant five echoed the need to use "a medicine man along with a with a Western medicine doctor ...with traditional medicines and putting out offerings like, you know, to the spirit of world." Participant six identified the need to smudge as a cultural tradition "I smudge, like, when I'm stressed, and that helps me."

### ***Indigenous-led Facilities and Approaches***

Participants reported nursing care received at Indigenous-led facilities differed greatly from the care received than at Western-led facilities and approaches. Participant four explained the nurse:

Was able to look beyond just the physical symptoms and really take into account what was going on again, mentally, emotionally, spiritually... So, the care I've received acknowledged my identity and my values, cultural practices, if they were applicable and that kind of care supports my spirit, not just my body, and feeling spiritually safe in care

Participant one recounted “knowing that I’m indigenous does help like, you know, because their approach would be like different than I’ve had other places. I guess you could say I don’t know if it’s like more of a taking the time to explain or knowing that it’s more family, or like different approach. I don’t know. I just I just find it just more comforting.” However, participant six felt differently about their nursing experience expressing “I would prefer they don’t know I’m Indigenous, unfortunately.” Participant six elaborated to say:

All these Indigenous-led facilities are Ojibwe names, you’d hope they’d be inviting spaces, but it’s not the same...I would have the Indigenous-led facility in general focus on their cultural awareness training more, because that needs a policy analyst or something. That needs a review.

### ***Met Health Needs***

Participants felt their health needs were met when they received nursing care that was genuine, used wholistic approaches, and honored First Nations cultural beliefs. Participant two felt “nurses that cared for me worried about my well-being so to speak, making sure I was comfortable...every one of them is there anything I can do for you, every one of them says to me that.” Participant four expressed “when you meet a nurse that has a genuine care for you and your situation. It’s very telling in comparison to maybe a nurse that’s not all that concerned about what’s going on with you.” Participant three highlighted:

Their [nurses’] bedside manner like they actually would talk to the patient like they’re compassionate... And they would ask about like their life or like, oh you

have like ...if my son would say, say a name they'd be like, Oh, who's that? Oh, that's my brother! Oh, you have a brother.

Participant six echoed nurses who are “just down-to-earth and very compassionate, which honestly is great when you have mental health, which can be so prevalent” resulted in their care needs being met. Participant six expressed that often Indigenous nurses or health care providers are the ones to integrate Indigenous cultural beliefs into care:

The Indigenous provider would be the only one who, if I was talking about, you know, a frazzled day, would probably be the only one to say, did you smudge today? You need to smudge...it just shows, like...That you hear us, maybe, first of all, maybe that you see us?

### **Summary**

This study aimed to answer the research questions of “what are the experiences of First Nation people’s in Northern Ontario when receiving nursing care to meet their wholistic health needs?” Through learning from the gift of stories in data analysis (Kovach, 2021), First Nation people’s from Fort William First Nation describe their experiences as negative nursing experiences resulting in unmet needs, nursing practice and nursing education needs change, and a need to honor and integrate First Nations beliefs into nursing care. Chapter 5 will interpret the study’s findings, describe limitations of the study, examine recommendations for future research, and identify implications for positive social change.

## Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative interpretive description study was to describe the experiences of First Nation people's in Northern Ontario receiving nursing care to meet their wholistic health needs. The study was guided by the two-eyed seeing framework (Bartlett et al., 2012; Rieger et al., 2020; Roher et al., 2021) and the Indigenous wholistic theory (Abolson, 2010). The study aimed to answer the following research question: What are the experiences of First Nation people's in Northern Ontario when receiving nursing care to meet their wholistic health needs? The study took place in Fort William First Nation, a First Nations community located in Northern Ontario within the Robinson-Superior Treaty area. The rationale for conducting this study was to understand First Nations people's descriptions of receiving nursing care to meet their wholistic health needs to address the gap in the literature regarding understanding First Nations people's wholistic health needs and ways of knowing and being (see Barbo & Alam, 2024; Batal et al., 2021; Vincze et al., 2021; Wu et al., 2023). Fort William First Nation participants described their experiences as negative nursing experiences resulting in unmet health needs, nursing practice and nursing education needing change, and a need to honor and integrate First Nation beliefs into nursing care. This chapter includes the interpretation of the study's findings, the limitations of the study, recommendations of the study, and implications of the study grounded in the stories of participants from Fort William First Nation.

### **Interpretation of the Findings**

The study's results confirm prior literature and extend it by offering new insights for nursing education and practice from the perspectives of Fort William First Nation participants. The two-eyed seeing framework and Indigenous wholistic theory provided a lens to analyze recent literature; develop interview questions; and aid in analyzing, interpreting, and making recommendations based on the participant narratives. Participants were not asked directly about racism, prejudice, or discrimination, but they shared their perspectives of this occurring in the nursing care received, resulting in codes of racism, equality and equity, identity, prejudice, aggression, neglect, and dismissal identified in participants' stories. Previous literature echoed similar experiences from Indigenous participants of reporting racism, prejudice, discrimination, barriers to adequate care, and unmet health needs (Josewski et al., 2023; Kitching et al., 2020; Phillips-Beck et al., 2020; Sehgal et al., 2023). Kitching et al. (2020) identified discrimination and unmet health needs when capturing Indigenous perspectives in Toronto, Ontario. Barbo and Alam (2024), through a systematic review, noted that Indigenous patients in Canada identified that discrimination and maltreatment resulted in inadequate and decreased quality of care. McLane et al. (2020) identified themes of experiences with racism and different treatment based on race shared by First Nations members in Alberta, Canada.

Theme 2 of nursing practice and nursing education needing change is echoed in the literature, as well as in accreditation and regulation standards for nursing practice and nursing education. Accreditation and regulatory standards set forth by the Truth and

Reconciliation Commission of Canada (2015) Calls to Action, Canadian Association Schools of Nursing (2025), College of Nurses of Ontario (2023), and Canadian Nurses Association (2017) identified that nurses in education and practice need to recognize and integrate Indigenous teachings, practices, and healing approaches into care. More recently, the Canadian Association of Schools of Nursing (2025) identified that nursing curricula need to adopt an antiracist, nondiscriminatory, decolonized, and strength-based approach focusing on cultural humility and cultural safety for Indigenous peoples' in Canada.

For years, literature has recommended changes to nursing practice and nursing education to ensure that culturally appropriate care is delivered to Indigenous patients to improve health outcomes. Participants in this study have confirmed that nursing practice and nursing education need to change to meet their wholistic health needs, which is confirmed in existing literature. Current literature notes that nurses lack knowledge of Indigenous peoples' and their wholistic health needs. Moreover, nurses in practice often lack the efficacy to care for Indigenous patients due to a lack of knowledge about Indigenous health needs, traditional healing practices, cultural values, and beliefs (Cassidy-Matthews et al., 2024; Horrill et al., 2022; Leclerc et al., 2020; Metheny & Dion Fletcher, 2021). Nursing education and training programs for nurses do not provide a thorough, informative discussion of Indigenous peoples' health needs or prepare graduates to deliver culturally appropriate care to Indigenous patients, despite accreditation and regulatory requirements (Turpel-Lafond, 2020; Yaphe et al., 2019). Vass & Adams (2021) accentuated that there is a lack of knowledge of Indigenous health

needs, and racism remains present in health education. Wiley et al. (2021) examined Indigenous cultural safety education training for health care providers and found that the current state of training for health care providers was inadequate.

Theme three further confirms existing literature while offering an enhancement of the current understanding, highlighting the need to honor and integrate First Nations' health beliefs through the stories of Fort William First Nation perspectives. Current literature identifies a strong need to understand the perspectives and lived experiences of Indigenous peoples' as recipients of care, to inform practice and education (Blanchet Garneau et al., 2021; Kennedy et al., 2022; Phillips-Beck et al., 2020; Wiley et al., 2021). Fort William First Nation participants identified deficiencies in nursing care related to addressing their First Nation wholistic health beliefs, the lack of cultural practices being acknowledged and integrated into nursing care, the lack of traditional medicine integration into nursing care, and an overreliance on the Western model of care and a focus on physical symptoms only. Participants shared their stories of receiving nursing care that had an overreliance on the Western approach and care that was only focused on their physical health. An overreliance on the biomedical model and physical health has been reported in the literature by Indigenous patients and researchers who have focused primarily on chronic disease prevalence (Asamoah et al., 2023; Eni et al., 2021). Also, participants recounted that nursing care met their wholistic health needs when it focused on their wholistic health beyond just their physical symptoms. Wholistic health for participants meant focusing care on physical symptoms but acknowledging the equal

importance of the interconnectedness and interdependence of their mental, emotional, and spiritual domains of health, and their cultural practices.

Participants shared that Indigenous-led facilities and their approaches to care acknowledged and integrated First Nation cultural practices, as well as the interconnectedness of First Nation beliefs with family, community, social support, and a personal, wholistic approach. These approaches from Indigenous-led facilities were identified as having positive effects and improving health outcomes for Indigenous patients (Kyoon Achan et al., 2022; Pilarinos et al., 2023; Wu et al., 2024). Although one participant noted that local Indigenous-led facilities and their approaches offer Ojibway names and traditional medicines, they felt it was merely for show. There is an opportunity for further improvement in the care provided to First Nation people's.

### **The Two-Eyed Seeing Framework**

The Two-eyed seeing framework informed the methodology, reflexivity of the researcher, data collection and data analysis. It was not used to analyze data in silo but rather used as a facilitator in analyzing the Western world of nursing and Western current research alongside the Indigenous participants stories they shared. The framework will be used to bridge the implications and recommendations in this chapter from participants' stories to nursing practice and nursing education. As someone who is both of Indigenous and settler heritage, I am also a nursing educator, practicing nurse, and novice researcher, and an Indigenous and settler patient. I have used my Indigenous worldview and knowledge system with one eye alongside my Western worldview and knowledge system with the other eye to see the good of all to aid in bridging the gap between the Western

model of health and the stories shared by Fort William First Nation participants (Bartlett et al., 2012; Reiger et al., 2020; Wright et al., 2019). As noted by Roher et al. (2021), the two-eyed seeing framework encompasses both Western and Indigenous knowledge systems allowing the ability to fully understand the world.

### **The Indigenous Wholistic Theory**

The Indigenous wholistic theory (Absolon, 2010) provided a contextual understanding of First Nations' wholistic health, which was used to develop a research-structured guide for interview questions. Absolon (2010) identified through their theory the interconnectedness, interrelatedness, and interdependence of the four elements: north, east, south, and west, encompassing physical, mental, emotional, and spiritual aspects of human beings. An Indigenous persons wholism is impacted by the historical, social, political, and economic factors integrated into the four directions (Absolon, 2010).

Participants shared stories of their wholeness and wholistic definitions of health, which aligned with the Indigenous wholistic theory that all aspects are interconnected, interrelated, and interdependent. The stories highlighted the connection to identity, land, community, cultural practices and traditions, and finding a balance in both the Western world and Indigenous world. Participants identified deficits in one domain of health like their spiritual health as having a negative impact on their other domains of health of mental, physical, or emotional. Absolon (2010) and Moscou (2022) highlighted that if there is an imbalance in one domain of health, healing could not occur. Three participants shared a direct link between their physical health and their mental health as they believe they work in harmony and are interconnected. Participants identified the strong

connection to every member of their community and how if one person in the community was suffering, it would affect them and the rest of the community, and they would all be suffering. Participants described feeling like their spiritual needs were never addressed as there was overreliance and too heavy of a focus on their physical needs leaving their needs unmet. As noted by Absolon (2010), spiritual health is closely interconnected with all four directions and four domains of health. Spiritual health is recognized as a growing importance of Indigenous peoples' but yet remains unaddressed in the care they receive (Burnett et al., 2022). One participant identified a waste of resources in treating what nurses believed was a physical need when it was actually a spiritual need, but the nurse never acknowledged this.

### **Limitations of the Study**

Credibility and trustworthiness were not limitations in the study as participants were verified to be members of Fort William First Nation through eligibility screening and interviews were conducted using semistructured interviews using community leadership approved screening. While data saturation was achieved with six participants, the community of Fort William First Nation is home to roughly 2,813 members which resulted in a smaller sample size (Lands Advisory Board, n.d.). The stories collected share First Nation knowledge and beliefs that may be unique to Fort William First Nation and cannot be generalized to all First Nation peoples'. As noted by the Chiefs of Ontario (n.d.), each First Nation community has unique cultural beliefs and traditions. However, it is evident the participants' stories and experiences confirm existing literature of Indigenous peoples' across Canada and internationally. Many researchers emphasize the

importance of learning from Indigenous lived experiences where nursing care or education is provided (Kennedy et al., 2022; Phillips-Beck et al., 2020; Wiley et al., 2021). As such, the participant stories, recommendations, and limitations in this study still hold substantial weight to offer positive social change for nursing practice and nursing education to improve health outcomes, quality of care, and the wholistic health needs of First Nation people's in Northern, Ontario.

### **Recommendations**

First Nations people's perspectives on their experiences receiving nursing care to meet their wholistic health needs confirm existing literature and add new recommendations for nursing practice, nursing education, and future research. All future research with Indigenous peoples' must honor Indigenous peoples' as collaborative partners in the research process and adhere to the principles of ethics and OCAP (Government of Canada, n.d.-h; First Nations Information Governance Centre, 2017; Kovach, 2021; Smith, 2021; Simpson, 2000). The study results allude to an additional research need to further explore targeted nursing interventions and targeted nursing education changes through capturing various stories of participants from Fort William First Nation. This study focused on their overall personal nursing experience. However, it would be beneficial to capture through focus groups the understanding of experiences for youth, adults, and elders on how nursing practice and nursing education can honor First Nations' wholistic health needs, cultural beliefs, and cultural traditions.

It would be beneficial to nursing practice and nursing education for future research to conduct similar studies in other First Nations communities in Northern,

Ontario to understand their descriptions of receiving nursing care to meet their wholistic health needs within their local geographical areas. Thunder Bay Regional Health Sciences Center (n.d.) is a regional hospital providing care to the people of Northern Ontario which is made up of many Indigenous treaty areas and home to hundreds of thousand Indigenous peoples'. Insights from this study and future research can be used to improve the care given to Indigenous peoples' at this facility and other local facilities in Northern Ontario. Western-led facilities located in other geographical regions in Ontario or Canada may conduct similar studies to understand the wholistic health needs of the Indigenous peoples' they serve and integrate the results from those studies into the wholistic care they provide to Indigenous peoples'.

Nursing education is regulated and accredited in the same way in the province of Ontario through the College of Nurses of Ontario and the Canadian Association of Schools of Nursing. It would be beneficial to explore current nursing education curriculum delivery to understand how nursing faculty are responding to Truth and Reconciliation Commission of Canada: Calls to Action (2015), Canadian Association Schools of Nursing (2025), College of Nurses of Ontario (2024), and Canadian Nurses Association (2017) regulations and accreditation standards in Northern, Ontario similar to that of previous literature of Doria et al., (2021), Metheny & Dion Fletcher, (2021), Pitama et al. (2018), and Vass & Adams (2021). Similarly, it would be imperative to capture the experiences of nursing students in learning about Indigenous history, Indigenous cultural practices, Indigenous wholistic health needs, and Indigenous

traditions in nursing education to determine if they feel prepared to deliver culturally appropriate care to Indigenous peoples’.

### **Implications**

This study used a qualitative interpretive description design, which was most appropriate to explore First Nations experiences in receiving nursing care to meet their wholistic health needs as it allowed for participants to describe and perceive their unique lived experiences and the researcher to interpret their experiences for practical implications in nursing practice and nursing education (Ravitch & Carl, 2021; Thorne, 2016). The interpretive description design provided an avenue to integration Indigenous research methods collaboratively (Kovach, 2021; Smith, 2021). The two-eyed seeing framework and Indigenous wholistic theory provided a solid foundation for gathering, understanding, describing, and interpreting participants’ stories from Fort William First Nations, correlating with nursing practice and nursing education which can be used in future studies.

This study provides timely insights into positive social change for nursing education and nursing practice in Northern Ontario. By capturing the experiences of Fort William First Nation participants in describing their experiences nursing experiences to meet their wholistic health needs, the findings emphasize an urgent need to address negative nursing experiences resulting in unmet health needs and integrate and honor First Nation beliefs in nursing care delivery and nursing education through making positive social change to nursing education curriculum and nursing practice.

## **Nursing Practice**

The time is now; nursing practice and nursing education need change. At an individual and organizational level, this study confirms that racism, discrimination, and prejudice continue to negatively impact First Nation people's, resulting in negative nursing experiences and unmet wholistic health needs. Participants recounted being asked to self-identify as Indigenous. However, they received no follow-up explanation of how that information helped ensure their Indigenous wholistic health needs would be met with that information. Indigenous peoples' become just another statistic with this approach, which is ethically unsound and mirrors how unethical research was conducted on Indigenous peoples' in history (Bull et al., 2022; Matheson et al., 2022). It is very much only data extraction with no benefit to Indigenous peoples' as noted throughout the literature (Kovach, 2021).

Participants are aware that their First Nations address is reflected on all their paperwork when receiving nursing care, which is identified through their stories of racism, discrimination, and prejudice while receiving nursing care. Together, these stories of Fort William First Nation participants pose questions many questions for individual nurses and organizations delivering nursing care to Indigenous communities. Why do health care facilities ask Indigenous patients to self-identify but not ask them about their cultural beliefs and practices, cultural preferences, and cultural traditions? How is their self-identity of being Indigenous shared with nurses to ensure the care delivered represents the beliefs of Indigenous peoples'? Why do First Nations people's home addresses that note a First Nations community need to be on all documents that nurses

see? How can this be changed to ensure it is not facilitating and exacerbating further racism, prejudice, and discrimination experienced by First Nations people? These questions require careful reflection and analysis to change practice for all individual nurses and organizations providing nursing care for First Nation people's.

Individually, nurses in Ontario are required by the College of Nurses of Ontario (CNO) (2023) to “provide inclusive and culturally safe care by practicing cultural humility” (p.6). This involves identifying biases, privileges, stereotypes, and assumptions that the nurse may hold, and taking action to address any discrimination against clients (CNO, 2023). Nurses must analyze health inequities, listen and understand the lived experiences of the clients, and meet clients' cultural needs (CNO, 2023). In addition, nurses must take “continuous education in many areas including Indigenous health care, determinants of health, cultural safety, cultural humility, and antiracism (CNO, 2023, p.7). According to the College of Nurses of Ontario's Code of Conduct (2023), the stories of Fort William First Nation participants indicate that nurses are not meeting their mandated regulatory requirements. Graham (2024) identified an urgent need to dismantle racism towards Indigenous peoples' through the CPR Racism approach. This can be used in nursing education and practice to provide a means for nurses, nursing students, and nursing faculty to confront racism. There is no place for racism in nursing care or nursing education; it must be eradicated.

### **Nursing Education**

Nursing education is required to integrate entry to practice competencies into curricula to ensure that nursing graduates are prepared to enter practice provincially. For

Northern Ontario, the entry to practice competencies 2.5, 6.1, 7.1, 7.3, 7.4, 7.14, and 9.3 identify that the registered nurse must address personal values and beliefs, reduce bias, acknowledge the Calls to Action, advocate for the use of Indigenous health knowledge and healing practices in response to the Calls to Action, advocate for health equity, acknowledge health disparities and optimize health outcomes, and engage in self-reflection from a place of cultural humility to foster cultural safety for all clients (College of Nurses of Ontario, 2019). The results from this study offer insights from the stories and experiences of Fort William First Nation participants that can be integrated into nursing education to adequately meet the entry to practice requirements for nursing students as mandated by provincial regulatory bodies.

First Nations people's want to be treated as equals with their unique history and cultural needs acknowledged. As noted by one participant, "We are humans. We're not less than. We're equal. We're beautiful. We're worthy." Nursing faculty can integrate antiracism and antidiscrimination approaches into curricula through self-reflection, self-awareness, and cultural humility to dismantle and address hidden biases, racism, prejudice, and discrimination that exist within nursing faculty and among nursing students. From here, nursing faculty can integrate Indigenous history into the curriculum so nursing students can understand the tragic history and continued colonization and cultural genocide that Indigenous peoples' face today. As noted by participants' stories and experiences, nursing education should focus on the history of Indigenous peoples' in Canada, understanding the provision of health care for Indigenous peoples', systemic racism, and understanding intergenerational trauma.

There are opportunities in many nursing courses to integrate First Nation health beliefs and cultural practices such as understanding that First Nations people's want space for Anishinabee medicines to be integrated alongside Western medicine, wholistic care approaches that hold equal weight to the physical, emotional, mental, and spiritual dimensions of health preventing the singular treatment of a physical symptom, or connection to community including people all people of their community as members of their family not just the Western definition of immediate family. One participant identified that because Indigenous peoples' are so diverse, nursing education should focus on the integration of local Indigenous peoples' needs into their curriculum, not just a standardized approach. This study offers key insights for positive social change to nursing education from a local level of Northern Ontario.

### **Conclusion**

Fort William First Nation participants in this study described their experiences in receiving nursing care to meet their wholistic health needs. The results from participants stories highlighted that nursing practice and nursing education need to change to honor Indigenous wholistic health needs and integrate Indigenous beliefs into care. Nursing practice in Canada is mandated and regulated to deliver culturally appropriate care to Indigenous peoples' that is free from racism, prejudice, and discrimination and that honors Indigenous cultural beliefs and practices to meet their wholistic health needs. Furthermore, nursing education must prepare graduates to practice in accordance with accreditation and regulatory standards of Canada through ensuring their delivery of care is antiracist and antidiscriminatory and they understand Indigenous history, Indigenous

wholistic health needs, and Indigenous cultural and traditional beliefs to deliver appropriate nursing interventions to meet Indigenous wholistic health needs. The results from this study provide a junction between the current delivery of the Western biomedical model and insights to integrate Indigenous wholistic health needs into nursing care and nursing education. The results from the study can improve nursing care and education to improve Indigenous health outcomes and reduce health disparities for Indigenous peoples' (Cassidy-Matthews et al., 2024; Eni et al., 2021; Horrill et al., 2022; Pilarinos et al., 2023). Through changing nursing practice and nursing education, Indigenous peoples' can receive nursing care that honors their cultural and traditional beliefs and meets their wholistic health needs beyond just a projection of the Western biomedical model.

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# FWFN WHOLISTIC HEALTH NEEDS - VOLUNTEERS NEEDED

## THE STUDY AIMS TO:

- Understand Fort William First Nation's Wholistic Health Needs
- Seeking Descriptions of Receiving Nursing Care
- Inform Nursing Practice, Nursing Education, and Future Research

A new study focuses on understanding the experiences of First Nations people in Northern Ontario when receiving nursing care to meet their wholistic health needs to inform nursing practice, nursing education, and future research. For this study, you are invited to describe your experiences in receiving nursing care to meet your wholistic health needs.

### About the study:

- One 60 minute in person or on zoom interview that will be audio recorded (no videorecording)
- You would receive a \$30 gift card to Walmart
- To protect your privacy, the published study will not share any names or details that identify you

### Volunteers must meet these requirements:

- Any Fort William First Nation adult aged 18 years or older. Must have received or accessed any form of nursing care in Canada in the last 2 years.
- Primary care providers and/or substitute decision-makers eligible.
- Self-identify as First Nation and belong to Fort William First Nation. Status and non-status members are eligible.
- Be able to read, write, and speak in English.

## MORE INFO

Please email [kara-anne.morriseau@waldenu.edu](mailto:kara-anne.morriseau@waldenu.edu), call 807-620-2846 or contact Kara Anne on Facebook privately to let them know of your interest. This interview is part of the doctoral study for Kara Morriseau, PhD student at Walden University. Interviews will take place during June & July

IRB #05-27-25-1169520



## Appendix B: Researcher-Developed Interview Questions

### **Preamble**

Thank you very much for participating in this study. I want to record this interview for transcription purposes to be used for my data analysis. The recording and transcribed Word file will remain in a password-protected folder for 5 years. A copy of the transcript and audio will be sent to my chair and committee members to ensure the accuracy of data analysis. However, I will not identify you in my documents, and no one will be able to identify you with your answers. Do I have your consent to record this interview?

As you know, the purpose of this interview is to understand your experience of receiving nursing care to meet your wholistic health needs. This should last about 60-90 minutes. During the interview, I will be typing notes via a Word document as I listen to your responses.

Once our interview concludes, I will review the transcript against the audio for accuracy and send it back to you for review.

Before we begin, it is important that I share with you who I am as the researcher in this role. I am of Indigenous and settler heritage that I acknowledge and honor as I learn my culture and learn to embrace Mino-Bimaadiziwin - The Way of a Good Life and my role in reconciliation as someone with settler heritage. I carry with me both my identities as they have played a pivotal role in shaping me into the person I am and into the researcher I aspire to be. I am an Anishinaabe kwe belonging to Fort William First Nation, where I have lived on reserve since I was a child. My settler heritage on my

mother's side brings a sprinkle of Italian, Ukrainian, Dutch, and Irish. I have the privilege of being able to live between both Western knowledge systems and Indigenous knowledge systems. I am a daughter, a sister, a cousin, an auntie, and a friend, but my most treasured title of all is being a mother and a partner. Western titles privilege me to add the following designations after my name: RN, MN, BScN and PhD candidate. These letters after my name have not come easily, nor have my family and ancestors been afforded the same privilege. I acknowledge I am a novice researcher trying to adhere to Western methodologies while integrating Indigenous methods to the best of my current knowledge base. I am Makwa Clan "Bear clan". The essence of my PhD journey involves protecting and advocating for the current generation and future generations through my research aspirations. This dissertation research comes from a place of purpose and passion.

As a practicing nurse and nursing educator, I have witnessed Indigenous peoples' in practice present with unmet health needs while having the Western biomedical model pushed as the only option to address health care concerns. I have witnessed racism and discrimination towards Indigenous patients from nurses and health care providers in the health care setting. I have witnessed nursing and health care curricula being delivered that are White-centered, colonial, prejudicial, racist, and intentionally or unintentionally dishonor Indigenous knowledge and ways of being. As a nursing educator, I have worked with many relations who lack knowledge of Indigenous wholistic health needs, contributing to the struggle to meet accreditation standards and adequately integrate

Indigenous health content into curricula. I am here today as a story listener to listen to the gifts of your stories so that I can begin to understand and learn from your stories.

Do you have any questions before we begin? If you need a break at any point, please just let me know. I do have an elder available should these questions or responses elicit any emotions or if you need to feel grounded in concluding this interview.

### **Demographic Questions**

- 1) Do you live on reserve or off reserve?
- 2) Is your community still remote or urban with road access?
- 3) Are you status or non-status?
- 4) How far is your community from a nursing or hospital facility where you would receive nursing care?
- 5) How long did you wait for an appointment or in the case of emergency how long did you wait to be seen?
- 6) What is your age? Gender? Occupation?

### **Main Questions**

- 7) What does wholistic health mean for you? How would you define wholistic health?
- 8) When and where was the last time you received nursing care?
- 9) Did the nursing experience occur at a Western hospital or an Indigenous-focused health care center?
- 10) How do you describe your experiences of receiving nursing care to meet your wholistic health needs?

- 11) How would you describe your experiences in receiving nursing care to meet your need for the interconnectedness of yourself, your family, your community environment, and your relationships?
- 12) What was the primary reason for seeking nursing care?
- a. Do you feel it is related to a physical, emotional, mental, or spiritual health need and why?
- 13) How would you describe your experience receiving nursing care to meet your physical health needs?
- a) *Follow up:* Did that nursing care meet your wholistic physical need?
  - b) *Follow up 2 (if no):* What was missing in the nursing care to meet your wholistic physical need?
  - c) *Follow-up 3: How did this impact your other domains of health?*
- 14) How would you describe your experience in receiving nursing care to meet your mental dimension of health?
- a) *Follow up:* Did that nursing care meet your wholistic mental need?
  - b) *Follow up 2 (if no):* What was missing in the nursing care to meet your wholistic mental need?
  - c) *Follow up Three: How did this impact your other domains of health?*
- 15) How would you describe your experience in receiving nursing care to meet your emotional dimension of health?
- a) *Follow up:* Did that nursing care meet your wholistic emotional need?

- b) *Follow up 2* (if no): What was missing in the nursing care to meet your wholistic emotional need?
  - c) *How did this impact your other domains of health?*
  - d) *Were you asked about your social networks or relationships?*
- 16)** How would you describe your experience receiving nursing care to meet your spiritual health?
- a) *Follow up 1*: Did that nursing care meet your wholistic spiritual need?
  - b) *Follow up 2* (if no): What was missing in the nursing care to meet your wholistic spiritual need?'
  - c) *How did this impact your other domains of health?*
- 17)** How would you describe your experiences in receiving nursing care to meet your cultural beliefs?
- 18)** *Were you asked about your culture, heritage, or cultural traditions?*
- 19)** *Were you asked about your Indigenous identity?*
- 20)** *Were you asked about your cultural beliefs, traditional teachings, traditional medicines, or ceremonies? (if no – how did that make you feel). (if yes – were you able to practice any of them)*
- 21)** Did you feel the care focused on one domain of health over the others? (if no – move forward) (if yes – which one and why)
- 22)** If you could change one aspect of nursing care you received, what would it be? And why?
- 23)** What should nurses know about Indigenous peoples' when providing care?

- 24) What do you think nurses need to understand about Indigenous peoples' wholistic health needs?
- 25) What do you wish you would have known before you received nursing care?
- 26) How do you think nursing education can integrate Indigenous peoples' wholistic health needs?

### **Conclusion**

- 27) Thank you for all of your answers today. Do you have anything else you'd like to share?
- 28) Are you comfortable if I reach out to you for a follow-up interview or to clarify any content from your interview if needed?
- 29) Do you have any questions for me?

**Thank you for your time. Goodbye.**