RACISM AND DISCRIMINATION AMONG NURSES IN CANADA AND THE IMPACTS OF THE COVID-19 PANDEMIC: A SCOPING REVIEW

June 2024

In Canada, we live, learn, and work on traditional Indigenous territories. We are all direct beneficiaries of policies of expulsion and assimilation of Indigenous Peoples during and since the time of settlement and Confederation. CNA acknowledges that the land upon which we are meeting is and continues to be the home of diverse First Nations, Inuit, and Métis Peoples. This acknowledgment is made with the recognition that nurses have a responsibility to learn the harsh and devastating impact that colonization has had on Indigenous Peoples past and present. We have a duty to respond to the Calls to Action of the Truth and Reconciliation Commission of Canada.

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Foreword

The Canadian Nurses Association (CNA) is pleased to receive and share the findings of the first of three phases of the research project Tackling Racism and Discrimination in Nursing in Canada. We are grateful for the funding support of the Canadian Institutes of Health Research (CIHR) ($443,000, 2022-2024) and the generous additional support for the larger program of work from the Johnson & Johnson Family of Companies in Canada. And for all their work to bring the study to life, we thank the leadership team: principal investigator Dr. Dzifa Dordunoo, co-investigators Dr. Josephine B. Etowa and Dr. Mona Lisa Bourque Bearskin, and the grant's named applicant, Michael Villeneuve. Thanks as well to the many other research team members, supporters, and students who have contributed so much to this important first phase of work – Aden Hamza, Tim Guest, Yacine Magassa, Melissa Markin, Clarisse Bosco, Claire Song, Jaymelyn Hubert, Tessa Wonsiak and Chantelle Bailey.

This important work arose in the wake of graphic examples of racism in the U.S. and Canada in spring and summer 2020, when CNA dramatically scaled up its work in the areas of discrimination and racism in nursing and health care. The death of George Floyd in the U.S. was followed soon after by the death of Joyce Echaquan in Canada, the latter taking place in a hospital in Quebec with members of the nursing team recorded while taunting Echequan shortly before she died. These examples, and others, were exposed perhaps more quickly and globally because the COVID-19 pandemic had so many places and people in lockdown. As then-president of the American Nurses Association (ANA), Dr. Ernest Grant (the first male, African American president of ANA), noted at the time, none of this was "news" to many — whether Black, White, Indigenous, or otherwise — as they were well aware of the ongoing harms of racism. However, many people who had not paid much or any attention to these sorts of crimes were home due to the lockdown and had time to notice for the first time. The result was a global wave of protests that brought significant attention to the issue of discrimination in institutions and the need to act.

Although CNA had been invested in work related to racism and discrimination in its ongoing social justice commitments and international programs over many years, it had been culpable — along with other nursing organizations, schools and institutions — in upholding systemic racism within the profession here at home. The report of the Truth and Reconciliation Commission of Canada had already moved CNA's work along, but during the quickly emerging Black Lives Matter movement of 2020, it was clear that nursing organizations had not been doing an adequate job in responding to racism. The events of the spring and summer of 2020 served as a stark wake-up call to act forcefully and strategically to tackle this longstanding injustice.

CNA moved quickly to convene a panel of Canadian and international experts in social movements to inform our work to combat anti-Black and anti-Indigenous racism. We declared racism a public health emergency, developed key messages on anti-Black racism in nursing and health care, worked with the Canadian Indigenous Nurses Association to issue a joint statement on the treatment of an Indigenous woman by nurses in Joliette, Quebec, and established an Indigenous Leaders Series. We also negotiated with a wide range of nursing associations and unions to collectively sign nursing declarations against anti-Black racism and anti-Indigenous racism in nursing and health care to outline our shared intentions to act. CNA hosted the first (2021) and second (2022) National Summits on Racism in Nursing and Health Care, bringing more than 500 delegates together during each event who were committed to moving talk to action.

This document, *Racism and Discrimination Among Nurses in Canada and the Impacts of the COVID-19 Pandemic: A Scoping Review* reports on, a) available evidence of the history and experiences of racism and discrimination in Canadian nursing, b) the impacts of COVID-19 on nurses and the delivery of nursing care in Canada, and c) interactions between the two dynamics, where available.

Already well underway, the second phase of work is a quantitative survey to describe the current representation and related demographics of the Canadian nursing workforce. The third phase uses a qualitative methodology to collect and report on the lived experiences of nurses of diverse backgrounds and identify barriers and enablers to diversity and inclusion. Finally, an overarching document will summarize the key findings and lessons from the three main reports and suggest key next steps for development of strategies to redress the disparities and inequities.

This first report of the larger study is an important step forward in Canada where we don't even know the racial make-up of the nursing workforce, for example, because we don't ask people if they would like to self-identify those sorts of characteristics during annual registration. As a result, we cannot really understand the scope or severity of the problem, let alone plan responses and strategies to confront racism and discrimination in our workforce. The work is long overdue, but CNA is pleased to be working with a group of committed individuals and organizations to help dismantle this brutal injustice within our ranks that is harming and holding back many of our colleagues.

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Introduction

Pre-pandemic, the Canadian health system faced several significant challenges at the federal, provincial and territorial levels that had negative implications for both health-care professionals (HCPs) and patients (Simpson et al., 2017). Not surprisingly, COVID-19 and its response requirements exacerbated these system vulnerabilities, placing additional pressures on health services, and created new barriers related to the scope, timeliness, accessibility, delivery and provision of health care across Canada (Canadian Federation of Nurses Unions [CFNU], 2021; Canadian Institute for Health Information [CIHI], 2022a; McMahon et al, 2020; Tiagi, 2022).

One important vulnerability is the ongoing, pervasive discrimination faced by ethnic minorities who work in and use these services. Recent studies show that patients in Canada — particularly those of Indigenous ancestry — experience racial and other kinds of discrimination when accessing the health system (Turpel-Lafond, 2020). Such negative experiences are associated with poorer outcomes for many populations across the country, but they are not limited to patients. Nurses from different racial backgrounds have also reported and expressed discontent about racial discrimination in their workplaces, though little is known about its scope or nature. Given the association between nurses, their practice environments and patient outcomes, gaining a broad understanding of these discrimination experiences can help shed light on how to better support nurses during these unpredictable times — which includes a critical workforce shortage due to attrition and the COVID-19 pandemic, among several other factors.

Background

Nurses represent the largest group of front-line health-care providers in Canada and globally (CIHI, 2022a; World Health Organization [WHO], 2020). In 2021, 459,005 regulated nurses had active licences in Canada (CIHI, 2022a). The country's regulated nursing titles include licensed and registered practical nurses (LPNs), registered psychiatric nurses (RPNs), registered nurses (RNs) and nurse practitioners (NPs), with educational requirements and levels ranging from two years for LPNs to six years for NPs (see Figure 1) (Almost, 2021).

Registered Nurse (RN):
A nurse with a baccalaureate degree who has either taken a collaborative college-university nursing program or a four-year university nursing program — leading to a bachelor of science in nursing (BScN) or bachelor of nursing (BN).

Nurse Practitioner (NP):
An RN with advanced university education who provides personalized, quality health care to patients (prescribing privileges vary across provinces and territories).

Registered Psychiatric Nurse (RPN):
A nurse with a diploma or degree from a psychiatric nursing program who has passed the Registered Psychiatric Nurses of Canada Examination (RPNCE). They directly care for those with mental illness, physical and developmental disabilities and addictions, and work to promote optimal mental health across community and health-care settings.

Licensed Practical Nurse (LPN):
Nurses who have earned a diploma in practical nursing through a college program of four semesters over two years. LPNs are regulated as Registered Practical Nurses in Ontario.

Figure 1. *Regulated Nursing Titles in Canada* (Almost, 2021)

Nurses and quality practice environments

A practice environment can be defined as the organizational characteristics that enhance or hinder professional practice and are correlated with morbidity, mortality and other patient outcomes (Lake, 2007). A quality practice environment supports the delivery of safe, compassionate, competent and ethical care while maximizing the health of clients and nurses, as per the Code of Ethics for Registered Nurses developed by the Canadian Nurses Association (CNA) (CNA, 2017; Duff et al., 2020).

Principles of quality practice environments

According to the Joint Position Statement on Practice Environments developed by CNA and the Canadian Federation of Nurses Unions (CFNU), quality practice environments must:

- provide a "safe and healthy practice environment, [which] is a fundamental human right"
- put "clients and their health-care needs at the centre of care and decision-making"
- be an essential part of "all domains of nursing practice (clinical practice, education, research, administration and policy) across the continuum of care"

- support nurses' and employers' obligation to "advocate for and contribute to quality practice environments" for their clients through the "organizational structures and resources necessary to promote safety, support, and respect for all persons in the practice setting"
- ensure that working in, receiving care in, governing, managing, and funding unhealthy health-care workplaces is unacceptable (p. 1).

In addition, quality practice environments should exhibit the following characteristics (which have been shown to optimize outcomes for clients, nurses and organizations):

- **Communication and collaboration:** Promoting "effective and transparent communication (including meaningful expressions of appreciation) and collaboration at the individual, organizational and system levels — among nurses, between nurses and clients, between nurses and other health and non-health providers, between nurses and unregulated workers, and between nurses and employers. Quality practice environments are based on trust and respect among clients, staff and employers" (p. 1).
- **Responsibility and accountability:** Helping "nurses fulfil their professional, legal, legislative and collective agreement requirements and [ensuring that] they can participate in decision-making that affects their work, including developing policies, allocating resources, and providing client care" (p. 2).
- **Safe and realistic workload:** Ensuring safe staffing in clinical practice by "matching nurses' formal educational qualifications and competencies to specific patient needs through evidence-based assessments" (p. 2).
- **Leadership:** Nurses "who act as collaborators, communicators, mentors, role models, visionaries and advocates for quality care also provide effective leadership. Therefore, all nurses have an important leadership role in how their workplace environment affects the care they provide" (p. 2).
- **Support for information and knowledge management:** Including technologies that "support critical thinking, the provision of safe and effective care, and optimal information and knowledge management (e.g., electronic health records and decision support tools)" (p. 2).
- **Professional development:** Allowing "nurses to access professional development opportunities, [which] can include formal and continuing education, mentoring and online learning resources" (p. 2).
- **Workplace culture:** Valuing the "well-being of clients and employees. [Such a] culture is continually assessed to ensure it embraces respect while developing 'practical knowledge [that] contributes to positive change, disseminating successful practices and strengthening health-care workplace cultures' to help improve client, nurse and organizational outcomes. Contributions to a positive workplace culture include, but are not limited to, policies that address ethical issues, support safety, create environments free of violence and bullying, promote employee recognition (e.g., awards) and ensure adequate resources" (pp. 2–3).

Further, "developing, supporting and maintaining quality practice environments" is a shared responsibility between "individual nurses, employers, regulatory bodies, professional associations, educational institutions, unions, health services delivery and accreditation organizations, governments and the public" (p. 1).

Why are quality practice environments needed?

Nurses work across traditional practice environments such as hospitals, nursing homes and home care but also in non-traditional settings such as correctional facilities, safe injection sites and nursing stations in remote Indigenous communities. Whatever the setting, nurses' practice environments are strongly associated with patient, nurse and organizational outcomes (Duff et al., 2020). Findings from international analyses of practice environments suggest that a negative work environment is correlated with 30-day mortality, failure to rescue, patient falls, hypotensive events, infection rates, medication errors and patient and family complaints (Dorigan & Guirardello, 2018; Kieft et al., 2014). A favourable practice environment is positively associated with survivability of in-hospital cardiac arrest, and those that have a higher proportion of nurses with an advanced level of education (i.e., bachelor's degree and above) are associated with decreased patient deaths (Aiken et al., 2003; Blegen et al., 2001; Cho et al., 2015; Estabrooks et al., 2005; O'Brien-Pallas et al., 2006; Young et al., 1991). Further, a favourable practice work environment has a positive association with job satisfaction and is negatively correlated with burnout and an intent to leave the current place of employment (Coetzee et al., 2013; Copanitsanou et al., 2017; Dordunoo et al., 2021; Klopper et al., 2012; Ma et al., 2015; Zhang et al., 2014).

In addition, evidence suggests that patients receiving care in specialized clinical units with higher quality practice environments, appropriate RN staffing levels and lower nurse-to-patient ratios have a shorter length of stay, lower in-hospital mortality, improved chances of survival to discharge and fewer health-care-associated infections (Aiken et al., 2002; Czaplinski & Diers, 1998; Kane et al., 2007; Kelly et al., 2013). Here, it is important to note, however, that while lower nurse-to-patient ratios improve patient outcomes, inpatient unit volume, acuity and intensity of nursing care confounds the relationship between patient-to-nurse ratios and outcomes (Dordunoo et al., 2017; Mackinon et al, 2015; MacPhee et al., 2017).

Despite these improved patient outcomes from higher quality work environments, "lateral violence" (defined as "deliberate and harmful behaviours" by nurses toward each other) is also well documented. Such behaviours, which can hinder nurses' ability to provide optimal care and negatively impact their own health (Christie & Jones, 2013), may involve racial discrimination toward particular groups based on colour and ethnic or national origin. To date, little evidence exists on the nature and extent of racial or other types of discrimination experienced by nurses in Canada (Registered Nurses' Association of Ontario [RNAO], 2022). These often go unreported or under-reported due to fear over actual or perceived repercussions on job security and career advancement (Saadi et al., 2023). Interestingly, perceived on-the-job repercussions (e.g., uneven distribution of workload or blaming systemic failures on an individual's incompetency) have been reported for decades. While these behaviours have been characterized as "nurses eating their young," little if any attention has been paid to whether they might be deep-rooted forms of (intentional or unintentional) racial discrimination — or more importantly, whether certain kinds of young are "eaten" more frequently.

Discrimination in Nursing

Overview

Discrimination is a serious public health issue and an important determinant of health inequity (American Psychological Association, 2022; Davis, 2020). It can generally be defined as the unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age, skin colour or sexual orientation (Equality and Human Rights Commission, 2021). Two main types of discrimination exist: individual and institutional (Williams et al., 2019).

Individual discrimination can refer to the interpersonal experiences between an individual actor and target and may include slurs, microaggressions, violence and threats of harm (Williams et al., 2019). People who have negative inherent beliefs and perceptions regarding personal characteristics may exhibit bias, prejudice and stereotyping toward people and/or groups. Intentional (explicit) discrimination occurs when an individual or group acts on these beliefs through aggressions (e.g., microaggressions such as microassaults) (Black et al., 2015; Gee & Ro, 2009). Unintentional (implicit) discrimination occurs when people are unaware that they are engaging in it; yet it can be just as harmful (Bertrand et al., 2005). Unconscious microaggressions can be further categorized into microinsults and microinvalidations, which undermine the experiences or beliefs of a group (Holley et al., 2016; Sue, 2010). Institutional discrimination can refer to discriminatory policies and practices favourable to a dominant group(s) and unfavourable to another group(s) that are systematically embedded in societal structures through laws, regulations, policies and other forms (Aronson et al., 2010).

Yet, whether individual or institutional, intentional or unintentional, all the discrimination that individuals or groups experience can be detrimental and lead to deleterious physical, behavioural and psychological outcomes such as stress (Lewis et al., 2015).

Racial discrimination in nursing

Racial discrimination means "any distinction, exclusion, restriction, or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life" (United Nations [UN],1965, p. 2). In Canada, systemic racial discrimination is a pervasive and complex health-system vulnerability. It needs to be addressed to ensure a "Just Culture" among HCPs, while recognizing that a diverse workforce is required to provide appropriate health care, something that aligns with the UN's Universal Declaration of Human Rights (UN,1948, 1965; Jefferies et al., 2019).

Racial discrimination can be further classified into *de jure* or *de facto* forms. *De jure* types are embedded in official laws and policies (e.g., policies that prohibited nurses of African descent from attending Canadian nursing schools) (Jefferies et al., 2022). *De facto* types refer to how such discrimination manifests in everyday life (e.g., through preconceptions about a group of people, often the result of *de jure* racial discrimination). Jefferies et al. (2022) describes how historical and contemporary anti-Black racist policies have manifested in nursing across Canada and have led to ongoing *de facto* racial discrimination such as limiting the leadership and career progression of Black nurses. These experiences of *de jure* or *de facto* racial discrimination can lead to negative physiological and psychosocial outcomes for nurses, including increased rates of anxiety, depression, burnout, exclusion and perceptions of invisibility (Jefferies et al., 2018).

Preliminary data from British Columbia (B.C.) reveals that both practising nurses and nursing students of African descent face widespread incidences of racial discrimination from colleagues and patients, creating unsafe and hostile practice environments (Coalition of African, Caribbean, and Black Nurses in British Columbia [CACBN], 2021). Further, evidence suggests that nursing students lack the knowledge, attitude and skills to navigate issues of racism and discrimination in clinical settings (Epp et al., submitted for publication). Although the full

extent of how nurses and nursing students in B.C. (and the rest of Canada) experience systemic racism is unknown, some evidence indicates that these experiences occur at the hands of nurses, and/or that nurses are often passive bystanders. However, there are no substantive processes for reporting them and no data to support their occurrence. Nor have any actions been taken to counteract them.

Amid calls for increased diversity in the nursing workforce, which is associated with improved patient outcomes (Jackson & Gracia, 2014; Phillips & Malone, 2014), it is important to acknowledge the historical racist origins of the nursing discipline based on the recreation and reinforcement of colonial ideologies within the profession. Pre-colonialization, nurses lived in various communities in what is now known as Canada. But the historical origin of present-day nursing is strongly linked to the French and British nursing traditions (Wytenbroek & Vandenberg, 2017).

These historical origins created structures that prevented non-European and non-Christian women from entering the profession. One example of the impacts of these structural barriers was the denial of admission into nursing schools for Indigenous and Black people in Canada (Eggertson, 2020; Henry-Dixon, 2021). In fact, the first Indigenous (Charlotte Edith Anderson Monture) and Black (Bernice Redmon) nurses received their nursing education in the United States (1914 and 1945, respectively).

Immigration laws further bolstered these structural barriers as people from selected European and other countries were not permitted entry into Canada until the 1970s (Canadian Council for Refugees, 2000). Moreover, those able to immigrate after the laws changed in 1970s encountered additional barriers, as education and licences from their country of origin were deemed unacceptable by Canadian schools and regulatory agencies. Incrementally, these barriers have led to a nursing workforce dominated by White female professionals, even when male-dominated professions such as medicine continue to see almost uniform male and female distributions in their workforce (Canadian Medical Association, 2018). Today, we need to recognize how these ideologies continue to exclude visible minority nurses from career opportunities and advancement, and how this injustice still manifests in the profession (RNAO, 2022).

Since CNA advocates and develops policies (or best practices) to strengthen Canada's nursing profession, it aims to address this persistent stressor (and other disparities) and its impacts on the health system's effectiveness (e.g., nurse workforce attrition) (CFNU, 2021; Nurses and Nurse Practitioners of British Columbia, 2021). Recognizing that visible minority nursing professionals are both susceptible to and victims of conscious and unconscious racial bias (and racist beliefs) that negatively affect their interactions with patients, communities, and co-workers, it is important to elucidate the nature (type), prevalence and distribution of this issue and how COVID-19 has exacerbated it. While some evidence exists on the pandemic's disproportionate effects on racial minority communities in Canada, CNA needs to better understand the nature of racism and discrimination as experienced by nurses, the negative impacts of the pandemic on the nursing workforce — across geographical locations, career stages and practice settings — and identify which factors facilitate systemic racism and bias. That said, knowing the scope of these issues is complicated by the paucity of available data and evidence (RNAO, 2022). There is also a lack of race and ethnic minority data for the kind of effective policy-making, decision-making and research needed to design, implement, monitor and evaluate interventions to address systemic racism in nursing (RNAO, 2022). Thus, this scoping review aims to map the available evidence in this area to help inform the future research activities of CNA and other stakeholders.

REVIEW QUESTIONS

Part 1. What is the available evidence on racism and discrimination experienced by nurses in the workplace across Canada?

Part 2. What are the impacts of COVID-19 on nurses and their service provision and delivery in Canada?

Methodology

We conducted a scoping review on the available evidence to address these research questions, which was informed by JBI methodology (Aromataris & Munn, 2020). We chose to ground our work in the larger context of human rights because health is a human right and nurses play a vital role in protecting their patients and communities:

The WHO Constitution (1946) envisages **"the highest attainable standard of health as a fundamental right of every human being."** A human rights-based approach to health is needed because it provides a set of clear principles for setting and evaluating health policy and service delivery while targeting the discriminatory practices and unjust power relations at the core of inequitable health outcomes. In pursuing a rights-based approach, health policies, strategies and programs should be designed explicitly to improve the enjoyment of all people to the right to health, with a focus on putting the furthest behind (i.e., most disadvantaged) first. Its core principles and standards include (non-discriminatory) accessibility and quality (e.g., safe and equitable) care (WHO, 2017).

Discrimination in general and racial discrimination, specifically, infringes on nurses' own human rights, hindering their abilities to be effective advocates and defenders of human rights. Therefore, the assumption in this review is that nurses' human rights are interconnected with the human rights of the public they serve. Here it is important to note that, while previous studies have established the positive association between nurses' work environment and patient outcomes, they have not explicitly evaluated the correlation between the human rights of nurses and patient outcomes.

Definitions

Racism:

Racism has been defined in different ways, but for this review we selected the definition developed by the UN:

An ideological construct that assigns a certain race and/or ethnic group to a position of power over others [based on] physical and cultural attributes, as well as economic wealth, involving hierarchical relations where the "superior" race exercises domination and control over others." (International Labour Office, International Organization for Migration, & Office of the United Nations High Commissioner for Human Rights [OHCHR], 2001, p. 2)

Article 1 of the United Nations Charter (1945) contains specific principles of non-discrimination responsible for "promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion" (para. 3). Despite being enshrined into international law as well as in its Universal Declaration of Human Rights, the UN determined that the principles of non-discrimination, specifically racial discrimination, be given more focused attention due to its ongoing global impacts (i.e., apartheid in South Africa and Jim Crow laws in the United States (U.S.). Consequently, in 1965 the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) was adopted by member states, and in 1969 it went into force (McDougall, 2021). ICERD defines racial discrimination as follows:

Any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life. (UN, 1965, p. 2)

ICERD specifically prohibits racial discrimination in all sectors, including public and private life. Failure to fulfil obligations under the convention would constitute a violation of the Declaration of Human Rights. As of 2021, ICERD has been ratified by 182 member states, with 88 joining as signatories (including Canada in 1966) (OHCHR, 2023).

The (modified) Action Continuum

Building on the model by McGibbon & Etowa (2009), this review situates its anti-racism conceptual framework on The Action Continuum. As described above, racism is an ideology that can underpin individual actions. It primarily operates on a continuum that simultaneously disadvantages and advantages individuals based on their physical attributes, most noticeably skin colour. In this way, all nurses can locate themselves on the continuum to decipher whether the system inherently advantages or disadvantages them. The modified continuum in Figure 2 describes how individuals can support or confront racism through their actions. Nurses can support racism by either actively participating in it or else denying or ignoring it. On the opposite end, nurses can educate themselves or take action to support themselves and others by preventing its occurrence. Such a framework enables CNA to develop strategies based on where individual nurses see themselves along the continuum. The findings of this scoping review also lay the foundation for those in the "actively participating," "denying/ignoring" and "recognizing-not acting" stages.

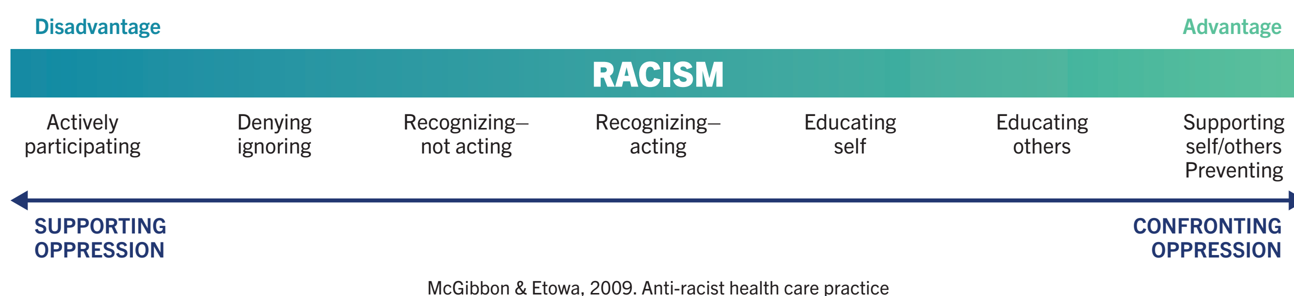

Figure 2. *Working for Social Change: The Action Continuum.* McGibbon & Etowa, 2009. Anti-racist health care practice

Study population

This review recognizes the term *nurse* as a protected title that denotes a person with education, training and licensure issued by a regulated body to carry out responsibilities according to their specific scope of practice. The regulated titles in Canada include registered nurse, nurse practitioner, registered psychiatric nurse and registered or licensed practical nurse (see Figure 1) (Almost, 2021).

Practice environments

Nurses have historically worked in various settings, the largest number in acute care within hospitals. For the purposes of this review, we included all traditional (e.g., acute and long-term care (LTC) and non-traditional settings (e.g., street nursing and nursing within the criminal justice system).

Review team and advisory committee

The scoping review team consisted of three nurse researchers (DD, JE, MLBB), a former CNA chief executive officer (MV), a former CNA policy lead (AH), a research coordinator (TW) and five research assistants (JH, MM, CB, CS, YM). The review team reflected RNs and nursing students from different racial and ancestral groups (e.g., Black, White, Indigenous, African, Asian and European) with team members who were fluent in both of Canada's official languages (French and English). After inviting several organizations to be part of our national advisory committee, seven agreed to do so and guide our project through participatory action research:

- Canadian Association of Schools of Nursing (CASN)
- Canadian Black Nurses Alliance (CBNA)
- Canadian Federation of Nurses Unions (CFNU)
- Canadian Nursing Students' Association (CNSA)

- CARE Centre for Internationally Educated Nurses (CIEN)
- National Collaborating Centre for Determinants of Health (NCCDH)
- Pan-Canadian Association Nurses of African Descent (PCANAD)

These organizations co-designed our scoping review through iterative input and feedback on the review's questions, protocol, study findings and followup studies.

Data sources and searches

The team devised a systematic search strategy in consultation with the research librarian to identify all relevant published research studies and reports using electronic databases. CINAHL, MEDLINE, PsycINFO, Academic Search Complete, America: History and Life (EBSCO), Scopus, Sociological Abstracts, Canadian Business and Current Affairs, and ProQuest were searched without date limiters.

This scoping review used a three-step approach. An initial limited search of MEDLINE, the Cochrane Database of Systematic Reviews, the JBI Database of Systematic Reviews and Implementation Reports, PROSPERO and CINAHL was followed by analyzing text words contained in the titles and abstracts of relevant papers, along with the controlled language index terms used to describe the papers. Second, we conducted a search using those identified keywords and index terms across all included databases, adapting the strategy when necessary to the search interface of each database. Third, we hand searched the bibliographies of all included reports and articles for additional studies and papers. A research librarian conducted the database searches; seven were conducted between April 20 and July 31, 2022.

In addition, we developed a search strategy incorporating databases such as ProQuest Dissertations and Theses and opengrey.eu, as well as relevant websites such as the Registered Practical Nurses Association of Ontario (RPNAO), the Ontario Nurses' Association (ONA), the British Columbia Nurses' Union (BCNU), and the Government of British Columbia, as recommended by the expert advisory committee, to identify grey literature that included unpublished studies. We used keywords based on those found in our initial database search strategies with iterative searches, as specified by the JBI framework.

We also conducted a sensitivity analysis to determine whether there was any crossover between "incivility" and "racism" in nursing. (This analysis found no overlap between the records using terms specific to racism and incivility.)

Study selection

Inclusion criteria:

We included studies that focused on regulated nurses in all types of practice settings in Canada and those in English and French that described racism and discrimination among the country's nursing workforce. This included reports of racism or discrimination between nurses, nurses and other HCPs, and patients targeting nurses and vice versa. We used online software to translate abstracts in languages other than English and French to determine their relevancy.

Exclusion criteria:

We excluded studies that included other HCPs such as midwives, health-care aids and other allied HCPs. Of note, while midwives and nurses can have similar training in other parts of the world, they are a distinct regulated health-care professional group in Canada with differences in training than regulated nurses.

All identified citations were collated and uploaded into Covidence (Veritas Health Information [Melbourne, Australia]) and had duplicates removed. Following a pilot test of several articles with 100 per cent agreement, team members (DD, TW, YM, JH, MM) independently screened all titles and abstracts for eligibility (each citation individually reviewed twice). Next, we retrieved full-text versions of potentially relevant studies, which were assessed against the inclusion criteria by one independent reviewer and against the exclusion by a second independent reviewer. Reasons for exclusion of full-text studies were recorded and reported, and any disagreements were resolved by a third reviewer. To facilitate open and transparent discussions by the review team — while recognizing the power dynamics within our group, which included students and university professors of different academic ranks — we created a code of conduct with input from each team member, so they could contribute to maintaining a safe and secure working space for respectful conflict resolution.

Data extraction and synthesis

We developed and piloted a standardized data extraction tool, developed by our research team, through which one independent reviewer from the project team (TW, JH, CS or YM) extracted data from the studies meeting the inclusion criteria. The data included specific details about the population, concept, context, study methods and key findings and was validated by another member of the review team (DD or TW). Iterative modifications to the draft data extraction tool were conducted as necessary during this phase. Authors of included studies were contacted to request missing or additional data, where necessary. Following data extraction, the primary review team met regularly to summarize the data using the review's conceptual framework. Any disagreements between reviewers were resolved through discussion until consensus was achieved. The draft findings were then presented to the national advisory committee and were updated based on its feedback, where required.

Quality assessment

Quality assessment was not performed as per the JBI guidance on scoping reviews.

Data presentation

The results of the searches are reported and presented as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). Narrative summaries of findings are presented which describe the available evidence on racism and discrimination in nursing in Canada (Part 1), along with the impacts of COVID-19 on the nursing workforce (Part 2).

Part 1. Racism and Discrimination Experienced by Nurses in the Workplace Across Canada

Summary of findings

We retrieved 3,291 records through initial searches and, after screening titles and abstracts, 1,399 records were removed (including duplicate records). Further screening resulted in 1,437 records being removed; of these, 456 full-text articles were assessed for eligibility, resulting in 167 being selected. An additional 15 reports were retrieved through our grey literature searches, resulting in 182 publications being included (see Appendix I). Included studies and reports were published between 1974 and 2022 (see Figure 3). While the publication trend varies over this period, with two distinct peaks in 1994 and in 2021, overall, it seems to have accelerated since 1990 with 169 (92.8%) of included reports published (see Figure 3). Of the included publications, only five were in French.

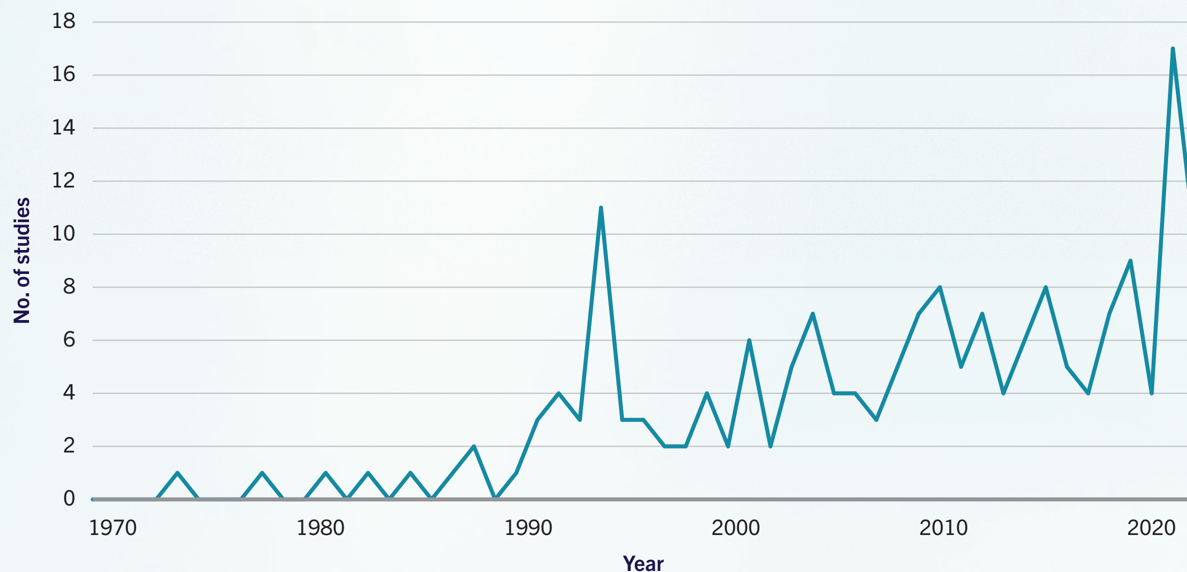

Figure 3. *Overview of Included Studies by Publication Year* (Part 1)

Study characteristics

Geographic location:

Most publications focused on regulated nurses in Ontario ($n = 71$) or were pan-Canadian reports with a subset of provinces or territories ($n = 67$). Other studies were conducted in or focused on one province, i.e., Quebec ($n = 8$), Nova Scotia ($n = 7$), Manitoba ($n = 5$), Alberta ($n = 4$), British Columbia ($n = 4$) and Saskatchewan ($n = 1$). Four publications were international studies that included Canada. In 11 publications, the geographical location was not reported (see Figure 4).

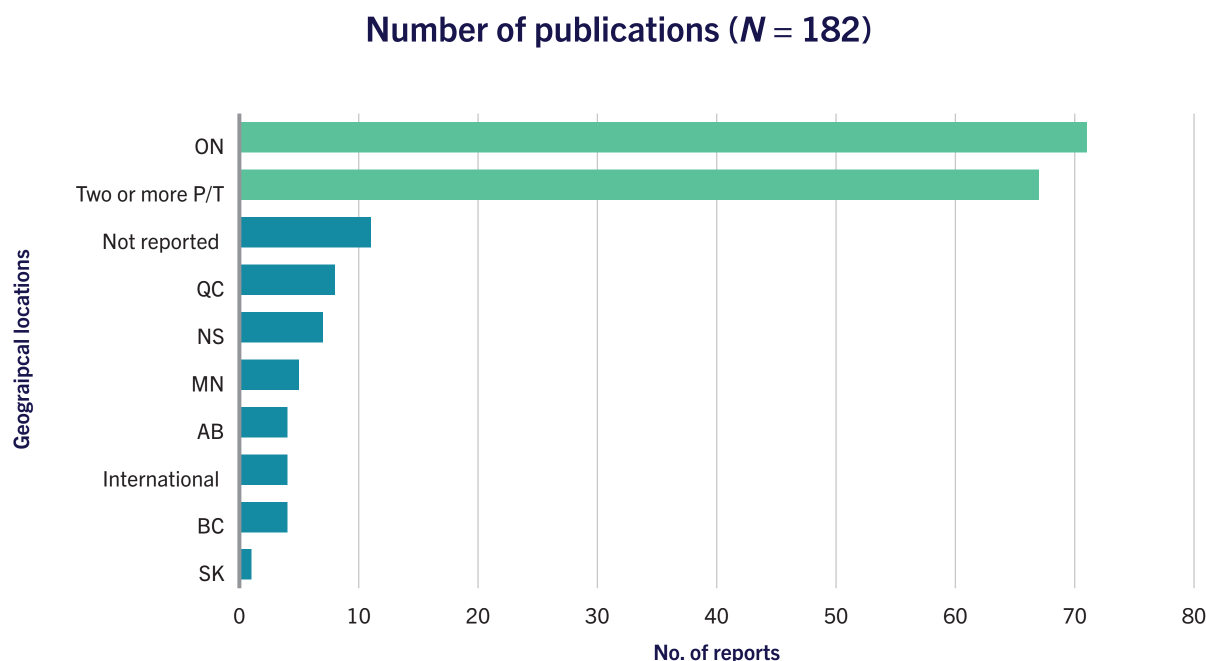

Figure 4. *Overview of Included Studies by Geographical Location* (Part 1)

Note: Publications conducted in two or more provinces or territories included those the study authors described as "Atlantic Canada" and "Western Canada." Studies categorized as international included those conducted in Canada and countries such as the United States and the United Kingdom.

Publication status:

Most included reports ($n = 79$) were published in academic journals as peer-reviewed papers, while 55 were published as grey literature (e.g., reports of court case adjudications in the media). Nursing organizations contributed to 21 publications, and 13 reports were either theses or dissertations. Nine studies were published in *Nursing Inquiry*, seven in the *Canadian Journal of Nursing Research*, five in *Labour (Journal of Canadian Labour Studies)*, four in *Nursing Leadership* and three in *Nursing Science Quarterly*. These represented the top five academic journals where included studies were published.

Population:

The retrieved reports mostly referred to the population as "nurses" ($n = 41$) or "regulated nurses" ($n = 26$) without distinguishing the regulated titles of nurses in Canada. Where the race of study participants was reported, 29 involved Black nurses, 15 broadly categorized participants as internationally educated nurses (IENs), 14 categorized participants as Aboriginal/Indigenous nurses and 3 as Filipino nurses. Other descriptors used for nurse study participants were Muslim ($n = 1$), West Indian ($n = 1$), African Canadian ($n = 1$), Nigerian ($n = 1$), and White nurse ($n = 1$). Only five studies reported the inclusion of male nurses. Here, it is important to note that,

due to socio-political influences on terminology, we used terms not currently accepted or used to retrieve publications, since a subset of indexed publications used previously accepted terminologies.

Settings:

Most publications (*n* = 169) focused on racism, racial and other forms of discrimination in numerous care settings, including hospitals; however, descriptions of the clinical departments or units involved were limited. The following settings were reported in less than 10 per cent of included publications: academia (*n* = 4), home care (*n* = 2), psychiatry (*n* = 2), maternity (*n* = 2), military (*n* = 1), residential or LTC (*n* = 1) and pediatrics (*n* = 1).

Evidence on racial and other forms of discrimination:

Following data extraction, the research team evaluated articles for evidence of racism, including Indigenous-specific racism, other racial discrimination and discrimination pertaining to gender, disability, sexual orientation, age, language and religion. Evidence of racial discrimination was found in 99 articles, followed by discrimination based on gender (*n* = 47), Indigenous-specific racism (*n* = 11), disability (*n* = 7), sexual orientation (*n* = 3), religion (*n* = 2), age (*n* = 1), language (*n* = 1), and multiple forms of discrimination (*n* = 11).

Racial discrimination:

The 99 articles containing racial discrimination were further classified by whether they contained evidence of *de jure* or *de facto* types. Forty-one articles described incidents of *de jure* racial discrimination, 22 described *de facto* racial discrimination and the remaining studies contained evidence of both (*n* = 36). *De jure* racial discrimination in nursing was exemplified in both historical and contemporary experiences. Historically, racial minority nurses were subjected to racist and exclusionary policies that limited their ability to obtain nursing education in Canada (Kulig & Grympa, 2006; Jefferies et al., 2022). More recently, *de jure* racial discrimination manifested in numerous ways, including barriers to IEN employment (Jefferies et al., 2022), a lack of racial minority nurses in leadership positions and critical care areas (Beagan et al., 2022; Cooper Brathwaite et al., 2022) and a deficiency in appropriate responses to incidents of racism in nursing education (Hantke et al., 2022). Examples of *de facto* racial discrimination included higher instances of workplace violence directed toward visible minority nurses (Boateng & Brown., 2021; Choiniere et al., 2013), increased instances of unjustified disciplinary action by leadership and experiences of racism from both colleagues and patients (Boateng & Adams, 2016; Neiterman & Bourgeault, 2015), leading to nurse attrition. One case of racial discrimination led to a judgment against an employer in Ontario after seven Black nurse plaintiffs alleged racist practices of termination without cause, dismissal and forced resignation, extended suspension without any pay, and continual harassment (Wong & Watt, 1991).

Gender-based discrimination:

Pay-related discrimination was one of the most common forms in the literature, primarily in reports of court cases adjudicated at the provincial or federal level. Examples included nurses losing employment insurance (EI) benefits based on their inability to work the required number of insurable hours due to child care responsibilities (Samarappuli, 2019; MacCharles, 2003). Numerous cases involving wage and pay gap discrepancies included the termination of two female nurses, who were then replaced by a male paramedic at a substantially higher hourly rate, in contravention of the Ontario Human Rights Code (Sklar, 1983); pay inequity for band nurses in comparison to male counterparts (Barnsley, 1999); and the classification of female nurses in medical adjudicator roles as "program administrators," while physicians in similar roles were classified as "health professionals," receiving higher pay and better benefits as a result (Klie, 2008; Butler, 2011). The Canadian Human Rights Tribunal awarded these nurses $2.3 million, acknowledging decades of sex discrimination by their employer — the federal government. This was one of the first of many settlements in which the government was ordered to compensate nurses for lost wages, dating back to the 1970s (Butler, 2011).

Despite regulatory approaches such as Ontario's Pay Equity Act, which aims to redress systemic gender discrimination in compensation for work performed by female employees, these approaches have been viewed as ineffective for pay inequity experienced by nurses because the Act is not gender neutral, nor does it facilitate an adequate comparisons of professions (Tiffany & Lutjens, 1993; Schreiber & Nemetz, 2000). Articles such as Schreiber and Nemetz (2000) discussed how Bill 124 in Ontario discriminated based on gender, since

“male-dominant” professions were excluded from the bill. The Ontario Nurses’ Association (ONA) has further argued that Bill 124 violates members’ constitutional rights to engage in free collective bargaining, discriminates against RNs based on sex and engages in systemic racial discrimination. Nurses are fighting to be exempted from Ontario’s wage suppression legislation, citing gender discrimination and systemic racism (ONA, 2020). Several studies saw regulatory approaches alone as insufficient to address pay inequities and proposed that a societal or cultural shift in the perception of nursing was needed to address these issues comprehensively, given the traditional view of nursing as “women’s work,” and thus not as valuable monetarily and socially (Gordon, 2001; Schreiber, 1993; Schreiber & Nemetz, 2000; Loriggio, 2021). Other forms of gender-based discrimination in the literature included the increased risk of violence toward nurses due to their gender, including sexual violence (Loriggio, 2021).

While most articles focused on the experiences of female nurses, some discussed the experiences of male nurses in Canada. Examples included the discrimination male nurses have faced historically, which includes exclusion from the profession and targeted harassment, both by colleagues and patients (Care et al., 1996; Hunter, 1974; Rajacich et al., 2013). Some study participants saw themselves as a “visible minority” and experienced resistance from colleagues and patients based on the stereotype of nursing as a female role, which led to job dissatisfaction (Rajacich et al., 2013). Another report suggested that some do not believe male nurses should work in maternity settings because they perceive it as a female specialty (Genua, 2005; Biletchi, 2013). Other studies have examined the gender differences and similarities, along with their role as predictors of job satisfaction among RNs in rural and remote communities. One study, which found that male nurses reported higher incidences of violence and aggression from patients, recommended an exploration of the workplace factors that can cause violence toward male nurses (Andrews et al., 2012). Other reports have highlighted that this same discrimination has led to feelings of being devalued in practice settings and subsequently poor self-esteem. Some of these reactions were triggered by depreciatory language and exclusionary communication in practice settings (Lagacé et al, 2008).

The solutions proposed in the literature to increase the number of male nurses include proactive recruitment approaches (e.g., the promotion of nursing as a viable profession, the use of role models and recruitment drives targeted at high schoolers) while devising and implementing strategies to address and reduce the gender stereotyping associated with nursing practice (Villeneuve, 1994; Rajacich et al., 2013).

Indigenous-specific discrimination:

The systemic and institutional racism highlighted in the literature include the structural inequities Indigenous people face when they access health care; for example, individual racism, HCPs’ inappropriate use of terminology and language, and neglect and poor communication regarding care provision (Crosschild & Varcoe, 2021; Vukic et al., 2012). Instances of inappropriate language included some nurses who, despite completing cultural sensitivity training, would label Indigenous patients with liver or kidney admissions as “drunks” or “addicts,” regardless of their etiology (Crosschild & Varcoe, 2021). One study, which examined the experiences of Indigenous nurse faculty and students in academic settings, found that lateral violence, tokenism and challenges negotiating identity as Indigenous people were among the key experiences encountered by study participants (Van Bewer et al., 2021). These experiences can be significant contributory factors to the lack of Indigenous nurses and nursing faculty across Canada, and often such experiences are not acknowledged or explored in academic and other settings (Vukic et al., 2012; Van Bewer et al., 2021).

Some reports discussed recruitment and retention issues among Indigenous nurses and nurse educators and suggested remedial initiatives such as mentorship for entry-into-practice Indigenous nurses (Arnault-Pelletier et al., 2006; Etowa, Mathews et al., 2010; Etowa, Perley-Dutcher, 2015; Kulig & Grympa, 2006; McCallum, 2016; Tombs, 2004; Zeran, 2016). A notable finding of this review is the distinct lack of literature pertaining to racism and racial discrimination against Indigenous nurses by other nurses, despite evidence of its occurrence (Crosschild & Varcoe, 2021; Eaker, 2021).

Discrimination based on disability:

Like gender-specific discrimination, many reports of discrimination based on disability were cases presented to human rights tribunals following disciplinary action or workplace dismissals (Underwood, 1988; Smith, 2015, 2019, 2021). One report involved a nurse with AIDS and Kaposi's sarcoma, who filed a complaint with the Ontario Human Rights Commission after being dismissed because of their condition (Underwood, 1988). Two reports involved nurses who were terminated because of disabilities (i.e., substance use disorders such as opioid use disorder). After complaints were filed against the employer, the commission found in both cases that, despite documenting their disabilities, the employer did not provide appropriate accommodations prior to termination (Smith, 2015, 2019). According to the Canadian Centre for Occupational Health and Safety (CCOHS), employers have a duty to accommodate a worker's needs in relation to a disability (either mental or physical), as per human rights legislation (CCOHS, 2022). Another report involved a nurse who was identified as a potential risk at a safety-sensitive site because they tested positive for cannabis; this nurse was prevented from working despite providing the employer with a medical marijuana prescription. The Newfoundland and Labrador Board of Inquiry found that the company discriminated against the nurse and did not seek reasonable accommodations (Smith, 2021).

Part 2. Impacts of COVID-19 on the Nursing Workforce in Canada

Summary of findings

A total of 1,839 records were retrieved from the initial database search. After the screening of titles and abstracts, 411 full-text articles were reviewed, and 262 records were included for data extraction for this part of our review (see Appendix II). These articles span from the beginning of the COVID-19 pandemic in March 2020 to June 2022 (see Figure 5). No French articles were identified.

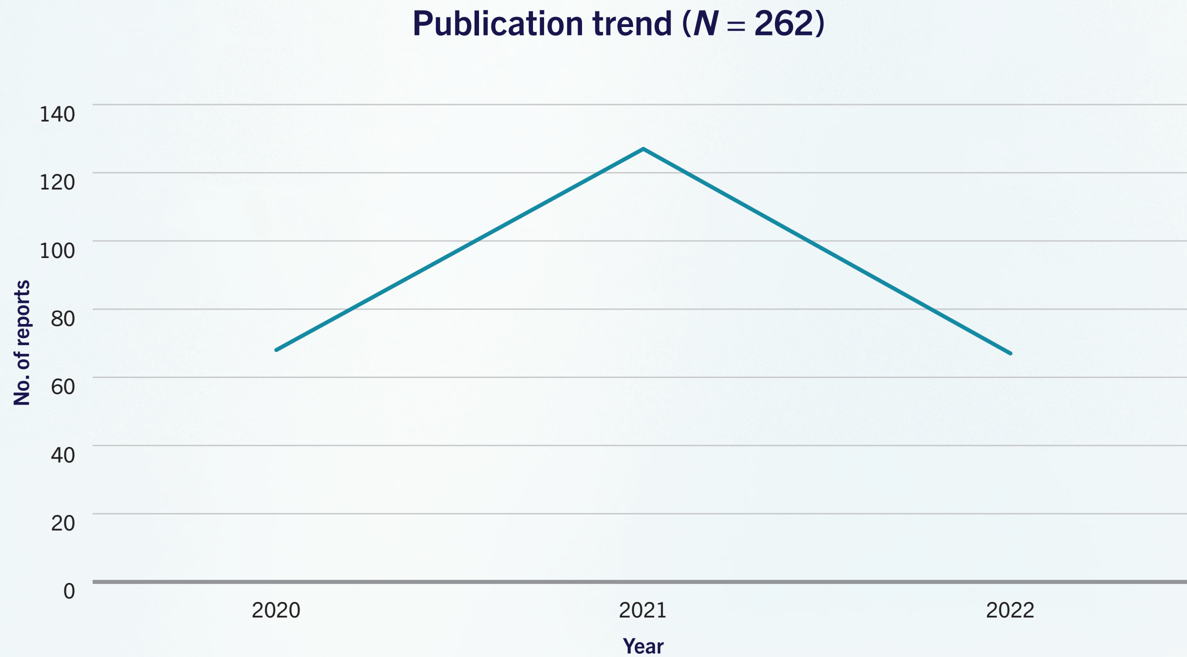

Figure 5. *Overview of Included Studies by Publication Year* (Part 2)

Note: Part 2 of the review included studies up to June 30, 2022.

Study characteristics

Geographic location:

Most included reports focused on regulated nurses in Ontario ($n = 90$) or were pan-Canadian reports ($n = 73$). Others focused on one Canadian province or territory, i.e., Quebec ($n = 26$), British Columbia ($n = 14$), Nova Scotia ($n = 13$), Alberta ($n = 12$), Manitoba ($n = 6$), Saskatchewan ($n = 4$), Nunavut ($n = 2$), Newfoundland and Labrador ($n = 1$) and New Brunswick ($n = 1$). Twelve publications were international and included Canada and other countries. Eight studies were conducted in four or fewer provinces (see Figure 6).

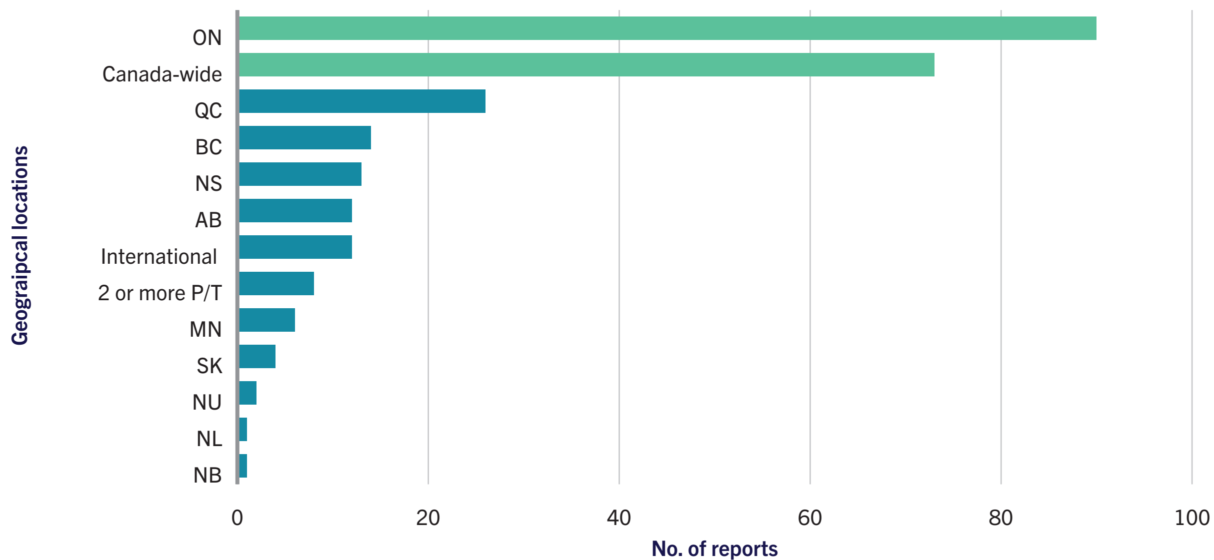

Figure 6. *Overview of Included Studies by Geographical Location* (Part 2)

Note: Publications conducted in two or more provinces or territories included those the study authors described as "Atlantic Canada" and "Western Canada." Studies categorized as international included those conducted in Canada and countries such as the United States and the United Kingdom.

Publication status:

Of the retrieved reports, 140 were news media articles and 118 were published in academic journals as peer-reviewed articles. Two reports were published by nursing organizations, and one conference abstract and one government publication were also included. Fifteen articles were published in *Nursing Leadership*, seven in the *Canadian Medical Association Journal*, five in the *Journal of Advanced Nursing*, and three each across four journals: the *Canadian Oncology Nursing Journal, Healthcare Policy*, *Nursing Ethics*, and the *Canadian Journal of Nursing Research*.

Population:

The retrieved reports used the terms nurses ($n = 111$), health-care workers ($n = 54$), and regulated or registered nurses ($n = 42$). For the remaining 55 studies, multiple terms were used such as nurse educators ($n = 8$), nurse leaders ($n = 8$), IENs ($n = 5$) and nurses from specialties such as oncology, mental health and hepatology.

Settings:

Most reports (*n* = 168) did not specify a study setting, since they were mainly grey literature (e.g., reports from professional organizations). Thirty-one focused on nurses' experiences in hospitals without providing information at the department or clinical unit level. Other study settings were described as long-term care (*n* = 31), emergency rooms (*n* = 7), academic settings (*n* = 7), acute care (*n* = 6), critical care (*n* = 6), and public health (*n* = 6).

Application of the Donabedian model:

The Donabedian model is a widely used theoretical framework that evaluates the quality of health-care services (Donabedian, 2005). Initially employed to assess medical care processes, it has since been used by other health-care disciplines, including nursing, to evaluate various health-related experiences (Kobayashi et al., 2010; McCullough et al., 2022). This model has also been used to guide nursing research in the context of the COVID-19 pandemic to assess the quality of care during a crisis (Binder et al., 2021; Jónsdóttir et al., 2021; Moayed et al., 2022). It evaluates quality of care by examining three interconnected components: structure, process and outcome. Structure measures components of the service provider, including staffing, accessibility and physical environment. Process measures care delivery services such as diagnostics, patient care requirements and preventive services. Outcomes are influenced by structures and processes and describe the overall effects of these two components on the quality of care (Donabedian, 2005; Kobayashi et al., 2010; McCullough et al., 2022).

Structure, process and outcome measures are synergistic and interrelated, with the ability to impact each other directly or indirectly. Using the Donabedian model, included publications were categorized based on their description of a health-care structure, process, outcome or a combination of the categories (see Table 1). Several reported structures of care which impacted nurses' ability to protect themselves and provide safe and effective care to patients during COVID-19. These were mainly associated with working conditions, such as the availability and distribution of personal protective equipment (PPE) and staffing levels, including nurses with expertise in COVID-19 management.

Various health-care settings described the unavailability and suboptimal distribution of personal protective equipment (PPE), including the lack of access to N95 masks (Arsenault, 2020; Arthur, 2020; DiManno, 2020; ONA, 2021a; Tutton & Doucette, 2020). For example, some reports highlighted the practice of rationing PPE to nurses who were at a higher risk of contracting COVID-19, since they were intubating or providing CPR to patients with COVID-19 (Tutton & Doucette, 2020). Other reports indicated that nurses did not have access to appropriate PPE for extended periods (e.g., up to a week), were reusing PPE that may have not been decontaminated or were reserving masks for patients who tested positive for COVID-19 (Arsenault, 2020; Arthur, 2020; DiManno, 2020; ONA, 2021b; Office of the Auditor General of Ontario, 2021).

Structure	Process	Outcomes
› Health-care facility capacity for pandemics, e.g., ICU availability › Working conditions (practice environments) › Availability of PPE (including N95 masks) and appropriate usage guidelines › Staffing levels and coverage › Public health policies and protocols › Regulatory policy updates › Psychological supports for nurses, such as mental health resources › Nurse leadership, including nurse managers and nurse educators › IENs' application and licensure processes	› Adaptive and innovative care delivery models, e.g., telehealth and telemedicine, including virtual care, telephone consultations and AI › Increased availability and distribution of PPE › Professional communication channels for nurses, e.g., for infection, prevention and control policy and protocol updates › Education and training for COVID-19 management, including PPE usage › Screening of employees, patients, residents and visitors for COVID-19 › Reduction or suspension of in-person contact › Improved hand hygiene protocols	› Lack of PPE and/or rationing or reusing PPE › Chronic staffing shortages › Health-care facility closures › Unsafe care provision and delivery › Mental and physical health impacts, e.g., anxiety, depression, exhaustion, burnout, stress, psychological distress, isolation and moral distress › Nurse and patient mortality › Racism and discrimination, e.g., microaggressions › Threats and instances of physical and sexual assault › Redeployment of nurses to areas outside their specialty › Interprovincial transfers for COVID-19 care › Suspension of non-urgent procedures and increased ER wait times › Unplanned and planned mandatory overtime › Nurse workforce attrition

Table 1. *Structure, Process and Outcome Measures Identified in the Review*

Chronic staffing shortages led to numerous direct and indirect effects on care provision and delivery. These included inadequate time to provide appropriate care in various settings, such as LTC and Indigenous communities (Ziafati, 2021); interprovincial transfers of ICU patients for care (Cukier, 2021; Ziafati, 2021); redeployment of nurses to areas outside their specialty, e.g., respiratory nurses and military nurses filling nurses' roles in other settings during the pandemic (Paperny & Lambert, 2022; Baig, 2021); suspension of non-urgent procedures; surgery back logs and increased ER wait times (Bissett, 2022; Baxter et al., 2022); mandatory increased working hours, e.g., working 24-hour shifts (Bains, 2021); unsafe staff-to-patient ratios (McLeod & Collins, 2021); and unsafe work environments (Gagnon et al., 2022). Chronic staff shortages also led to health facility closures, e.g., ER and health-centre closures in northern communities such as Nunavut, which put patients at risk (Blake, 2022; Tranter, 2022).

Several studies reported on the impact of COVID-19 for the nursing workforce at the individual level (particularly ICU nurses). This included mental and physical health impacts such as anxiety, depression, exhaustion, burnout (some due to violence and harassment), stress, psychological distress (e.g., from witnessing family grief), isolation and moral distress. Such experiences led to nurse workforce attrition, among other outcomes (e.g., undertaking measures to avoid working with COVID-19 patients) (Anzola et al., 2022; Côté, et al., 2022; Havaei et al., 2022; Lavoie-Tremblay et al., 2022; Mehta et al., 2022; Maunder et al., 2021, 2022; Mohammed & Lelièvre, 2022; Rhéaume et al., 2022; Sahashi et al., 2021). One report indicated that 66 per cent of nurses experienced burnout during the pandemic, alongside corresponding deficiencies in psychological support from their practice settings (during and after the pandemic) (Mental Health Research Canada, 2022). A number of reports suggested that nurse

leaders could have supported their staff in creating safe practice environments by increasing professional communication and promoting access to mental health supports (supplemented by educational and training opportunities on COVID-19 management) (Lefebre et al., 2020; Almost, 2021; Jeffs et al., 2021; Strudwick, 2021).

Racism and discrimination:

Interestingly, only four reports discussed the role of COVID-19 in exacerbating racism and discrimination (Narine, 2022; Clarke, 2021; Shang et al., 2021; S [anonymized], 2021). For example, 23 Manitoba Keewatinowi Okimakanak member nations declared a state of emergency for health services. One report described this as a direct result of health disparities faced by resident Indigenous populations due to entrenched racism and discrimination, noting that this was further exacerbated by COVID-19 and nursing shortages in 21 nursing stations (Narine, 2022). Another report examined the experiences of Indigenous populations during COVID-19 in four countries, including Canada. As in other jurisdictions, Indigenous populations experienced higher negative outcomes when compared with non-Indigenous populations, e.g., higher rates of death and mental health conditions (Clarke, 2021). It also mentioned how Indigenous nurses were overwhelmed while providing care during the pandemic, since they were managing patients with pre-existing and ongoing health inequities (Clarke, 2021).

In addition, the literature reported increased instances of anti-Asian discrimination toward nurses, pre- and post-pandemic (Shang et al., 2021; S [anonymized], 2021). One report, in describing the nature of discrimination faced by Asian nurses in Canada and the U.S., found a substantial increase in racial microaggressions related to COVID-19. These experiences, which came mainly from colleagues, patients and their family members, included being questioned about their health status (e.g., COVID-19) and ethnic origin. They involved Asian stereotypes as well. Other examples of discrimination included direct avoidance or rejection of care and statements such as derogatory racial stereotypes, alienating statements and explicit racial profanities. Also reported were threats of physical and sexual assaults and one case of actual physical assault. At the same time, study participants indicated that there was a lack of institutional acknowledgment and response to instances of discrimination (Shang et al., 2021).

One study exploring the impact of the “nurse as hero” narrative during the pandemic suggested that this narrative, while possibly seen as public support for nurses by politicians and decision-makers, in fact conceals, preserves and reinforces existing power structures, including racism and gender discrimination (Mohammed et al., 2021).

Discussion

Our review set out to identify and summarize the available evidence on the racism and discrimination nurses experience in workplaces across Canada, as well as the impacts of COVID-19 on their service provision and delivery and to what extent the pandemic contributed to systemic racism and discrimination.

In Part 1, we found no published studies prior to 1970 that described racism and discrimination faced by nursing professionals in Canada, with the majority published after 1995. Most reports were either Canada-wide or focused on regulated nurses in Ontario or a subset of provinces (e.g., Western Canada). Few studies were conducted in the Northwest Territories, Nunavut and the Yukon. Reports generally did not distinguish protected regulated titles in their study populations (e.g., nurse practitioner); instead, they used generic terms such as "nurse" or "regulated nurse." We suspect that some authors might have been referring to unregulated health-care workers when categorizing nurses.[1] Descriptions of nurses' ethnicity were also limited (specified in less than 40 per cent of studies). As well, while reports described nurses' experiences in several care settings (e.g., hospitals or LTC), they provided limited descriptions at the unit or department level.

Our scoping review shows evidence of the racism and discrimination experienced by ethnic minority nursing professionals across all domains of practice in Canada. At the same time, there was a lack of recommendations for interventions to remediate or prevent such occurrences in practice settings in published reports. Racial discrimination was the most common element in the included reports, and it involved both *de jure* and *de facto* types. *De jure* racial discrimination is embedded in legislative and policy structures and was exemplified in the literature through historical exclusionary policies for attaining nursing education, among others (Kulig & Grympa, 2006; Jefferies et al., 2022).

Barriers to access and advancement within the nursing profession have also been reported more recently, such as the lack of ethnic minority nurse leadership in clinical settings (Beagan et al., 2022; Cooper Brathwaite et al., 2022; Jefferies et al., 2022). In addition, as this review highlights, there has been longstanding discriminatory practices against IENs (Jefferies et al., 2022). Provincial government actors have a history of recruiting such nurses at times of critical nursing shortages (e.g., from the Philippines) (Damasco, 2019; Higginbottom, 2011; Neiterman & Bourgeault, 2015; Nourpanah, 2019; Ronquillo, 2012). While such actors modify immigration and registration processes for these recruited nurses, the same is not offered to IENs who immigrate to Canada independently. In fact, recruited nurses are often put in leadership positions. These *de jure* and *de facto* practices of racial discrimination create a multi-tiered system that can lead to experiences of unequal treatment between nurses recruited internationally, those immigrating as individuals and Canadian-trained nurses.

As in other reviews, the literature identified evidence of *de facto* racial discrimination, including ethnic minority nurses experiencing higher incidences of bullying, harassment and discrimination from colleagues and patients, in conjunction with unwarranted disciplinary action (American Nurses Association [ANA], 2018; Boateng & Adams, 2016; Boateng & Brown, 2021; Choiniere et al., 2013). However, no systems were in place to report discriminatory practices and experiences outside of HR systems, which have traditionally been poor at acknowledging or implementing policies to address them.

Organizational cultures need to evolve and develop supportive infrastructures that address discriminatory practices and incidents as a high priority. However, their under-reporting by nursing professionals compounds the difficulty (Karatuna et al., 2020). Reasons for under-reporting may include fear of punitive repercussions, a lack of supervisory and/or co-worker support, doubts that reporting will result in appropriate remedial actions, a mistrust of reporting systems or structures, lateral power dynamics and isolation, and exclusion (Arnetz, 1998; Arnetz et al., 2015; Gates, 2004; Sato et al., 2013; Kvas & Seljak, 2014). Unfortunately, it can lead to underestimating the actual extent, prevalence and effects of incidents. In turn, this recognition gap can limit the development of preventive measures since, with the lack of reports, there may be an assumption that workplace discriminatory incidences do not occur (Arnetz et al., 2015).

1 As the national voice for the nursing profession, it is difficult for CNA to advocate for change when specific designations are not identified. This suggests that further engagement is needed to increase awareness of the various regulated nurse designations and their scopes of practice.

Despite widespread accounts of the racial discrimination experienced by nurses in Canada, only one incident has led to a favourable court ruling for the plaintiffs. While the country's nurses are unionized, our review identified no additional cases of such discrimination within the legal system after 1991, even though most retrieved reports were published after 1990.[2] Nurses who have experienced racism and/or racial discrimination have complained that union representatives act as gatekeepers preventing them from escalating their concerns (CACBN, 2021). This suggests that union collective agreements are preventing individual nurses from taking unilateral action on incidents of racial discrimination. Although union advocacy efforts to address these issues are ongoing, a collaborative approach between key stakeholders (i.e., nurse regulators, health authorities, health-care settings and nurse advocacy organizations) is needed if there is to be stronger action to protect nurses' human rights within their practice settings.

Evidence of gender-based discrimination in the literature was found in biased regulatory policies such as the *Pay Equity Act* and Bill 124, which did not adequately address systemic gender discrimination in compensation for female-dominant professions like nursing. Such strategies were viewed as ineffective because they did not address wage and pay gap discrepancies between nurses and other male-dominant health professions like medicine. In other jurisdictions, pay gaps negatively affect ethnic minority nurses, and there are significant disparities between female and male annual earnings, despite the implementation of the *Equal Pay Act* in the U.S. Access to EI benefits in Canada was another type of discrimination reported in the literature. A number of court cases highlighted how nurses with child care commitments were unable to access or keep these benefits because they were unable to work enough hours to qualify (Samarappuli, 2019; MacCharles, 2003). Although the reports found that female nurses experienced higher incidences of violence and harassment, emerging evidence shows that male nurses are experiencing higher levels of violence and aggression from patients (Andrews et al., 2012; Loriggio, 2021).

Disability-related discrimination included dismissals due to health conditions (e.g., AIDS and substance use disorders), where nurses were terminated without appropriate accommodation despite their employers' being aware of their disabilities (Underwood, 1988; Smith 2015, 2019).

We found a distinct lack of published literature on racism and racial discrimination against Indigenous nurses by other nurses and HCPs. Most reports focused on Indigenous experiences of traditional health-care systems and the experiences of Indigenous nurse faculty and students in academic settings, which included tokenism and coping mechanisms such as hiding Indigenous identities (Crosschild & Varcoe, 2021; Vukic et al., 2012; Van Bewer et al., 2021).

To address these issues, reports recommended that an Indigenous research and policy agenda that embodies decolonization, reconciliation, and transformation within and beyond nursing be urgently prioritized. This approach could be supplemented by government funding to develop and sustain initiatives and programs that improve Indigenous experiences by investigating important issues such as Indigenous nurse and faculty attrition (Etowa et al., 2015; Gregory & Harrowing, 2012; Kurtz et al., 2017; Van Bewer et al., 2021). Recognizing the pressing need to decolonize health care and nurse education, a number of recommendations to address and mitigate Indigenous-specific racism in nursing have been proposed for nurse leaders. These include:

- Underpinning all actions by a structural understanding of how the culture, norms, traditions and organization of nursing is deep-rooted in colonialism.
- Basing all actions on a collective commitment to anti-racism and decolonization at every level in education, research and practice.

Crosschild and Varcoe (2021) have further proposed a call to action that includes the following priority areas:

- Monitor and respond to discriminatory practices in every domain of practice such as hiring, performance reviews, promotion, budgetary decision and leadership selection.
- Redesign curriculums for undergraduate/post-graduate nurses and teaching practices to decolonize nursing education at all levels.
- Address Indigenous-specific racism in health care and education through policy, education and research.
- Develop, implement and evaluate policies and practices to ensure and sustain the recruitment and retention of Indigenous health-care providers.

2 Of note, more cases of gender discrimination have been adjudicated by the legal system since 1991.

As in other publications, the second part of review confirmed that the COVID-19 pandemic exacerbated pre-existing systemic stressors and barriers faced by nurses, including ethnic minority nurses. This effect has led to nurse workforce attrition and other negative outcomes, including inadequate staffing, high burnout rates and increasing levels of mental health disorders (see Table 1) (CFNU, 2021, 2022; Carrière et al., 2021; Murphy et al., 2022; Stelnicki et al., 2020). Many of these outcomes were related to suboptimal working conditions due to the lack of PPE, the limited capacity of health-care facilities to manage COVID-19 patients, unclear messaging regarding COVID-19 protocols and policies, and a lack of psychological supports for nurses. Other factors that could have impacted the nursing workforce supply during COVID-19 include delays in IEN applications and licensure processes, which could have potentially filled nursing shortages (Baumann et al., 2021; Winsa, 2021). Notably, there were limited descriptions in the literature of how COVID-19 exacerbated experiences of racism and discrimination by nurses. Only two reports described the experiences of Asian nurses.

Canada experienced higher death rates in LTC settings than other countries during the first wave of COVID-19, some of which were preventable (Estabrooks et al., 2020; Sepulveda et al., 2020). Between March 2020 and February 2021, over 14,000 LTC residents died, which represents more than two-thirds of Canada's total COVID-19 deaths (CIHI, 2021). Over a similar period, the number of RNs and LPNs employed in direct care in LTC settings and by community health agencies declined by 2.2 per cent and 0.8 per cent, respectively (CIHI, 2022b). One study examined the institutional factors associated with deaths in LTC facilities (among other factors), found that the severe LPN shortages and small-to-medium-sized facilities were associated with 30-day mortality in Quebec (Zhang, et al., 2022). Interestingly, LTC and critical care were significantly impacted during COVID-19 in terms of shortages of nurses trained in critical care and high mortality rates among residents. These findings suggest that reports of structural problems should be prioritized and embedded into strategies for optimizing emergency planning and management.

A recent report has highlighted ways to improve outcomes for patients in LTC settings. These include increasing the availability of PPE; screening employees, residents and visitors for COVID-19; reducing or suspending in-person contact; and improving hand hygiene protocols (Statistics Canada, 2022). Further, among nine recommendations for addressing the workforce crisis in nursing homes in the Restoring Trust: COVID-19 and the Future of Long-Term Care report was to implement national standards for these settings. Other recommendations for LTC resiliency and responsiveness during pandemics included ensuring adequate supplies of PPE and appropriate testing for residents, staff and visitors (Canadian Centre for Policy Alternatives, 2020).

Recommendations

Several recommendations were proposed to address racism and racial discrimination across all spectrums of nursing practice. These include education, policy and research to implement, support and maintain inclusivity and civility (see Figure 7), i.e., active behaviours that embody "mutual respect, [promote] communication and [foster] collaboration among nurses and patients and the health-care team (Lower 2012)" (ANA 2018, p. 3; RNAO, 2022). Strategies could also include interventions to identify and facilitate reporting on discriminatory practices, supplemented by ensuring the implementation of quality practice environment principles (CNA & CFNU, 2015; CNA, 2017).

Recommendations to address racial discrimination in nursing practice

Acknowledge that systemic racism and discrimination exists at individual, organizational and policy levels. All nurses must self-identify and address their individual biases. Organizations must encourage them to continually engage in reflective practice and delve into their perceptions and experiences to assess inherent biases and values.

Ensure that intentional or blatant discriminatory practices are not tolerated and are immediately addressed.

Advocate for diversity in leadership, senior, administrative and educational roles in the nursing profession and in other health sectors.

Develop and implement training and orientation in anti-racism, anti-oppression, cultural safety and diversity, equity and inclusion for staff at all levels in all workplace and academic settings.

Include diversity, equity and inclusion committees in all workplaces and academic settings to address racism and discrimination.

Hold all staff (professors, managers, health-care providers) accountable for addressing racial discrimination and develop specific strategies to combat it.

Have nurses engage in self-reflection about their personal and professional values regarding civility, mutual respect and inclusiveness, and resolve any potential conflicts in ways that promote patients' best interests and safety.

Have nurses seek out and support practice environments that embrace inclusive strategies and promote civility and mutual respect regarding patients, co-workers and community members.

Have nurses advocate for inclusive policies that promote civility and human rights for all health-care workers, patients and others in the organization and community.

Have nurses encourage all health-care agencies to adopt and maintain policies, procedures and practices that embrace inclusiveness, promote civility and mutual respect, contain methods for reporting violations and require interventions to avoid recurrence.

Have nurses work to create diverse, inclusive communities that promote, protect and sustain high-quality, effective, efficient and safe health-care practices, both within the profession and with other health-care professionals, social workers, clergy and advocacy organizations.

Ensure that nurses in all environments and at all levels embrace the concepts of justice and caring, diversity and inclusiveness, and civility and mutual respect as guiding principles in the provision of health care.

Encourage nurse researchers to support and conduct inquiries that are inclusive in nature and involve studies of diverse populations and their health-care needs.

Enable nurse managers, supervisors and administrators to assess policies to ensure that they support inclusiveness, civility and mutual respect, while acknowledging that the lack of such policies may result in environments that fail to sustain high-quality, effective, efficient and safe health-care practices.

Encourage nurse educators to promote a diverse workforce by developing education practices to attract and retain students from all backgrounds. As the number of diverse nurses in the workforce grows, it will better reflect the diversity of the overall population.

Encourage nurses to embrace a patient-centred approach that responds to the individual cultural needs and concerns of their patients and families.

Develop and enforce policies on anti-racism, e.g., zero tolerance of racism from staff, nursing leaders, patients, and families.

Collect and disseminate race-based data.

Provide tools and resources to support Black nurses as they navigate difficult challenges when dealing with residents, patients or families who display racism.

Figure 7. *List of Recommendations for Addressing Racial Discrimination in Nursing* (not exhaustive). Adapted from ANA, 2018; CFNU, 2022; RNAO, 2022.

Impacts of COVID-19 on nurses in Canada and their service provision and delivery: A conceptual framework

Short of world wars, the COVID-19 pandemic was arguably the most disruptive global force many of us have experienced. Its impact was felt in most countries, with infections of nearly 800 million people and close to seven million deaths (as of March 2023) (WHO, 2023). Apart from the virus's direct health impacts, the responses to it disrupted economies, brought health systems into crisis and put hundreds of millions of people temporarily or permanently out of work around the world.

As a microcosm of society, nurses in Canada were severely impacted by all these dynamics. But unlike workers outside of health systems, HCPs spent their working hours immersed in or impacted by the care of people who were suffering from the virus.

In light of the volume and complex interplay of factors affecting Canada's nurses, in what follows we have visually organized our review's work, findings and outputs in a framework to help situate its impacts in nursing.

Let us consider the framework in three steps.

Step 1:

The backdrop of the framework proposes that individual nurses operate within two worlds — their professional world in health care and their personal world in the larger society. Within the professional world, nurses may impact and/or be impacted by the five domains of practice, i.e., clinical care, education, administration, policy and research (see Figure 8). Step 1 assumes that there were societal and health-system dynamics that existed before the pandemic that may or may not have changed since it began.

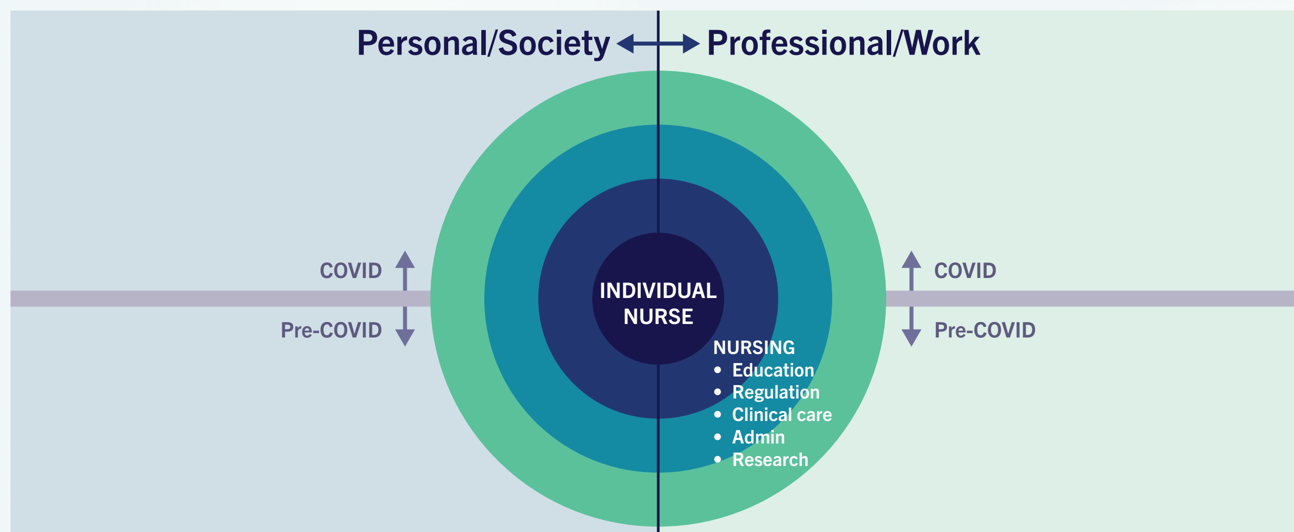

Figure 8. *Conceptual Framework* (Step 1)

Step 2:

The framework proposes that individual nurses are aligned with their immediate teams (or clinical microsystems), workplaces, larger organizations and health systems in their professional world (see Figure 9). Their personal world may include many components such as family and/or friend groups, hobbies, cultural interests, sporting activities, travel, worship, etc., all of which are influenced by public policy development and decisions.

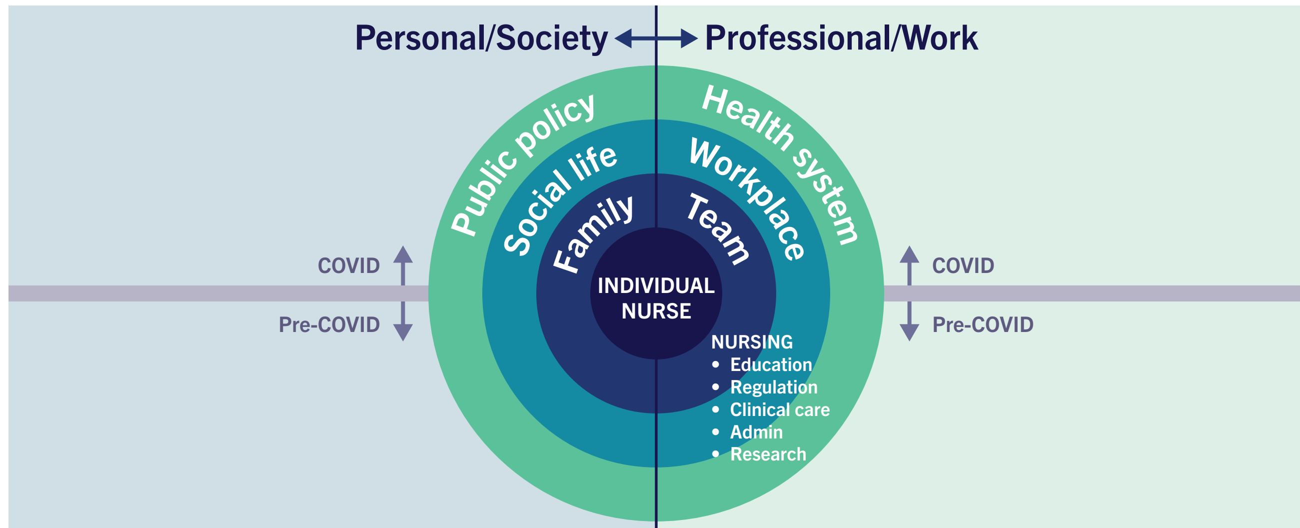

Figure 9. *Conceptual Framework* (Step 2)

Step 3:

The third step of the framework shows the major dynamics and forces identified in the literature review. Some were reported at the individual, team, organizational and/or health-system level (see Figure 10).

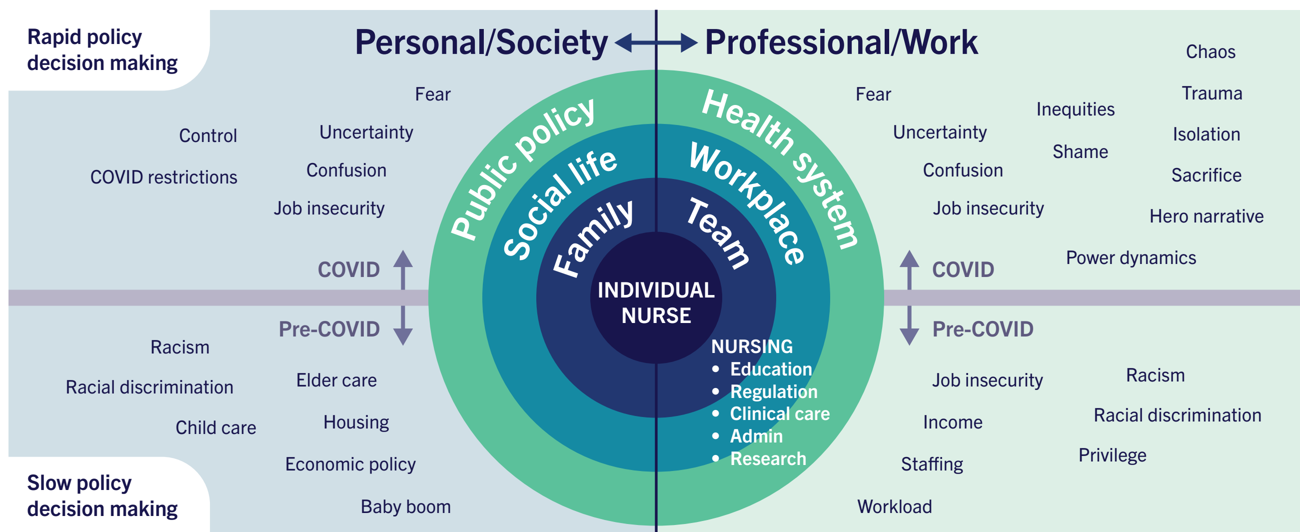

Figure 10. *Conceptual Framework* (Step 3)

I. Professional world, pre-pandemic

Before COVID-19, nurses faced several key interacting forces in their professional world. For example:

- Job insecurity, which ties directly to concerns about income security.
- Longstanding staffing and workload concerns. These not only relate to safety but also to job satisfaction and intentions to change jobs.
- A long history of racism, racial discrimination and the effects of privilege accorded to some people and groups, the most obvious being the backdrop of Whiteness and White supremacy in nursing and health care.

II. Professional world after the pandemic started

Since COVID-19 arrived, some of these important dynamics continued, while others changed considerably. For example:

Racism and discrimination:

Racism, racial discrimination and privilege continued to exert their effects. Some nurses were saying (anecdotally) that inequities worsened during the pandemic, with certain power dynamics becoming more evident and concerning.

Problematic practice environments:

Many practice settings were described as chaotic, uncertain, confusing and permeated by fear — in some cases, these related to untenable staffing and workload levels, compounded by personal fears of contracting COVID-19.

Nursing professionals and mental health:

Nurses reported feeling the effects of isolation, trauma and shame, even while their self-sacrifice was being noted publicly and tied to a near-global hero narrative. One analysis found that this hero narrative reinforced perceptions about the nursing profession by concealing, preserving and reinforcing existing power structures, including gender discrimination.

Job security:

The pandemic shifted job insecurity to job security quite rapidly, since increasing levels of work were required, despite the fact that the nurse workforce supply was insufficient to meet the demand.

III. Personal world and society pre-pandemic

Generally, there was a sense that public policy development across all sectors, including health systems, took too long when it came to making decisions on major issues. Before COVID-19, nurses had reported living with the effects of well-known, seemingly perennial social issues that have antagonized successive federal, provincial, territorial, municipal and Indigenous governments for decades — among them, child care, elder care, and housing security. Every person in Canada is impacted by the economic policies and practices of all levels of government, and these policies in turn have become increasingly influenced by the demographics and needs of an aging generation (baby boomers). Currently, the country has about 7.3 million seniors (65 and older), about 20 per cent of the total population (CIHI, 2017; Statistics Canada, 2023). During COVID-19, many people in this age group decided to retire earlier than planned (including nursing professionals), which contributed to nurse workforce attrition. Here, it must be made clear that the pandemic merely accelerated what had been forecasted since the late 1940s and did not cause this urgent public policy problem, which had gone unanswered for decades. Additionally, as in nurse practice settings, racism and discrimination were being experienced and reported in the personal world.

IV. Personal world and society after start of the pandemic:

After COVID-19 began to spread, the personal world of nurses was characterized by the same sorts of fears, uncertainty and confusion faced by the general public. Some of the fears nurses experienced involved the possibility of spreading the infection to their children, elderly parents and others. Rapidly shifting public health policies — including restrictions such as wearing masks, self-isolation, and (eventually) vaccines — also increased fear and confusion. When these dynamics led to a global conspiracy movement, which included the widespread sharing of mis- and disinformation, many nurses found that they had little or no stability in their personal or professional world.

One positive dynamic noted after the start of the pandemic was a rapid increase in the pace of public policy development. In some cases, this led to the dismantling of longstanding practices that had never added any value to the experiences of health-system users. Within health care, an obvious example was how quickly the virtual care Canadians had wanted for decades was facilitated — removing within a couple of weeks the century-old practice of requiring all care to be delivered in person (WHO, 2023).

Review limitations

Our scoping review is not without limitations. We did not assess the quality of studies as per the JBI methodology, nor any bias within reports (e.g., media or publication bias). We also recognize that most publications included in the review focused on nursing professionals in Ontario, and there was little or no representation of other provinces and territories (i.e., the Northwest Territories, Nunavut and the Yukon). Many reports used terms such as “staff” or “nurses,” so we were unable in these cases to distinguish whether support workers and/or regulated nurses were the focus. This also meant that we were unable to determine the extent to which nursing designations were impacted by racism and discrimination, while recognizing that some designations may experience racism more frequently than others. Although lateral violence and incivility exist in nursing, with experiences that are similar to racial discrimination, it is unclear whether characterizing these as such minimized reports of racial discrimination in the included publications. We will ensure that we address these issues within the next phases of our research.

Conclusion

Our review provides several insights into the pervasiveness of racial and other forms of discrimination experienced by nurses in Canada. Yet, for organizations, it appears that developing safe, quality practice environments that support those who go through such experiences may not be a priority, since appropriate systems to address them are lacking. Not only are substantive processes for reporting racism and discrimination lacking, the actions taken to counteract and prevent their occurrence or recurrence have also been limited. As a result, there is a paucity of data and evidence regarding this important systemic issue (RNAO, 2022). This gap is further compounded by the significant dearth of race and ethnic minority data, which is needed for effective policy-making, decision-making and research. In turn, both are needed to design, implement, monitor and evaluate interventions to address systemic racism and discrimination in nursing and their associated outcomes for patients (RNAO, 2022) and to inform health-system preparedness, resiliency and recovery efforts from epidemics and pandemics (Ontario Health, 2021). Addressing discrimination and its negative effects on nursing professionals could help improve nurse retention and ensure that nurses can practice in the care settings of their choice.

Next Steps

The findings from our scoping review (Phase 1) show that further research is necessary to elucidate the pervasiveness of racism and discrimination experienced by nursing professionals (within nursing designations and across practice settings) in Canada. This need will inform the next two phases of this work, through which we will aim to address what we found more specifically.

Phase 2 will involve a national, cross-sectional survey of nurses in Canada, which will be the first national survey that examines the nature and extent of systemic racism experienced and witnessed by nurses in Canada. It will also aim to explore the impacts of COVID-19 on the nature and frequency of racism and discrimination in practice settings and generate nurse-level and system-level data for evidence-based decision-making and policy-making. We will adapt the Everyday Discrimination Scale (EDS) and similar tools to assess the experiences and impacts of racism while collecting anonymized data on participants' demographics (Jefferies et al., 2019; Williams et al., 2019). For example, EDS survey dimensions include chronic work discrimination and harassment, heightened vigilance and mechanisms for coping with discrimination (Williams et al., 2019). We will produce and publish a summary report of our findings as part of our knowledge translation strategy.

Phase 3 will leverage findings from the first two phases. Here, we will conduct in-depth, semi-structured interviews and focus groups with key informants (knowledge experts), ensuring that there is a diverse representation of nurses, including those with lived experience of systemic racism and discrimination in health care. We will aim to recruit nurses across the spectrum of practice (e.g., education, administration and/or work contexts that including clinical and non-clinical settings). In addition, groups will include entry-to-practice nurses and nurses at different career levels (with provincial and territorial representation). These stakeholder engagement activities will further explore the lived experiences of nurses from diverse backgrounds and identify enablers, barriers and opportunities related to justice, equity, diversity and inclusion.

A final summary report will include policy and practice recommendations for key stakeholders such as nurse regulators, nurse educators, employers and policymakers. Here, we will develop recommendations for devising, implementing, monitoring and evaluating interventions for addressing racism and discrimination within nursing (including during pandemics) while emphasizing the need to improve the collection of nurse- and system-level demographic data, such as race and ethnicity data and racism and discrimination incidence data in Canada. We will also develop tools and resources for nurse professionals and health-care organizations for addressing systemic racism, including logic models for service evaluation and performance optimization for policy and practice interventions.

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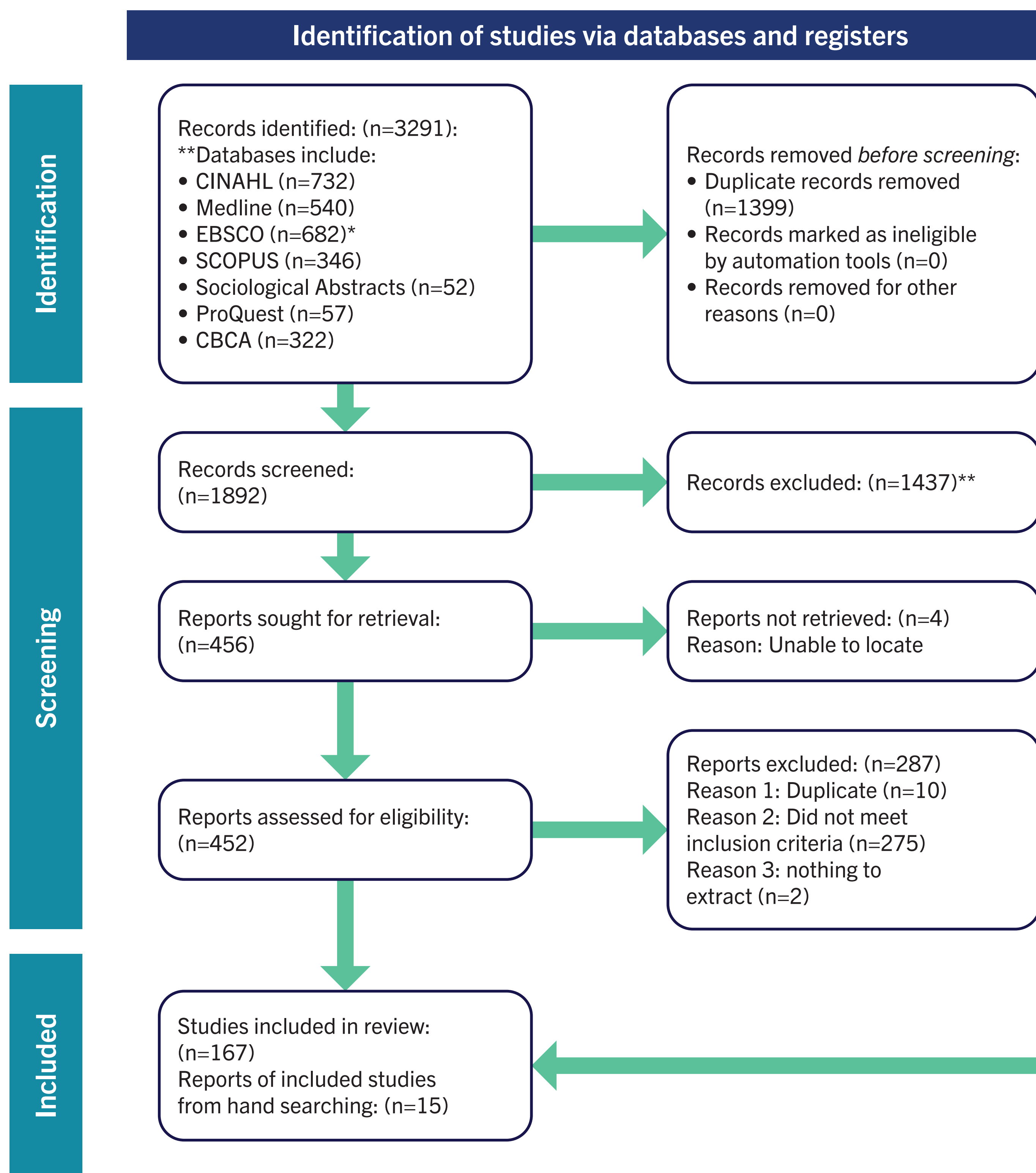
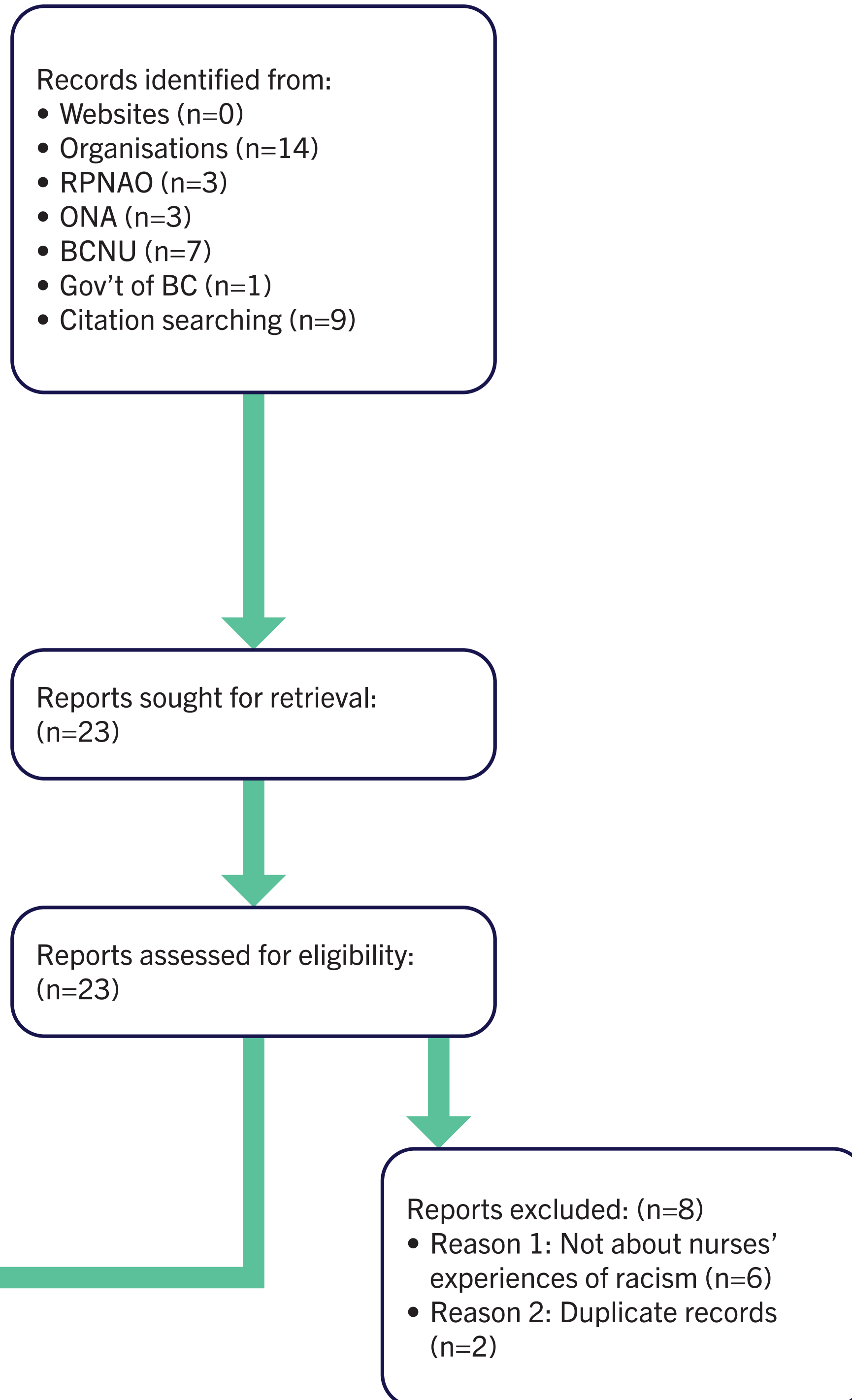
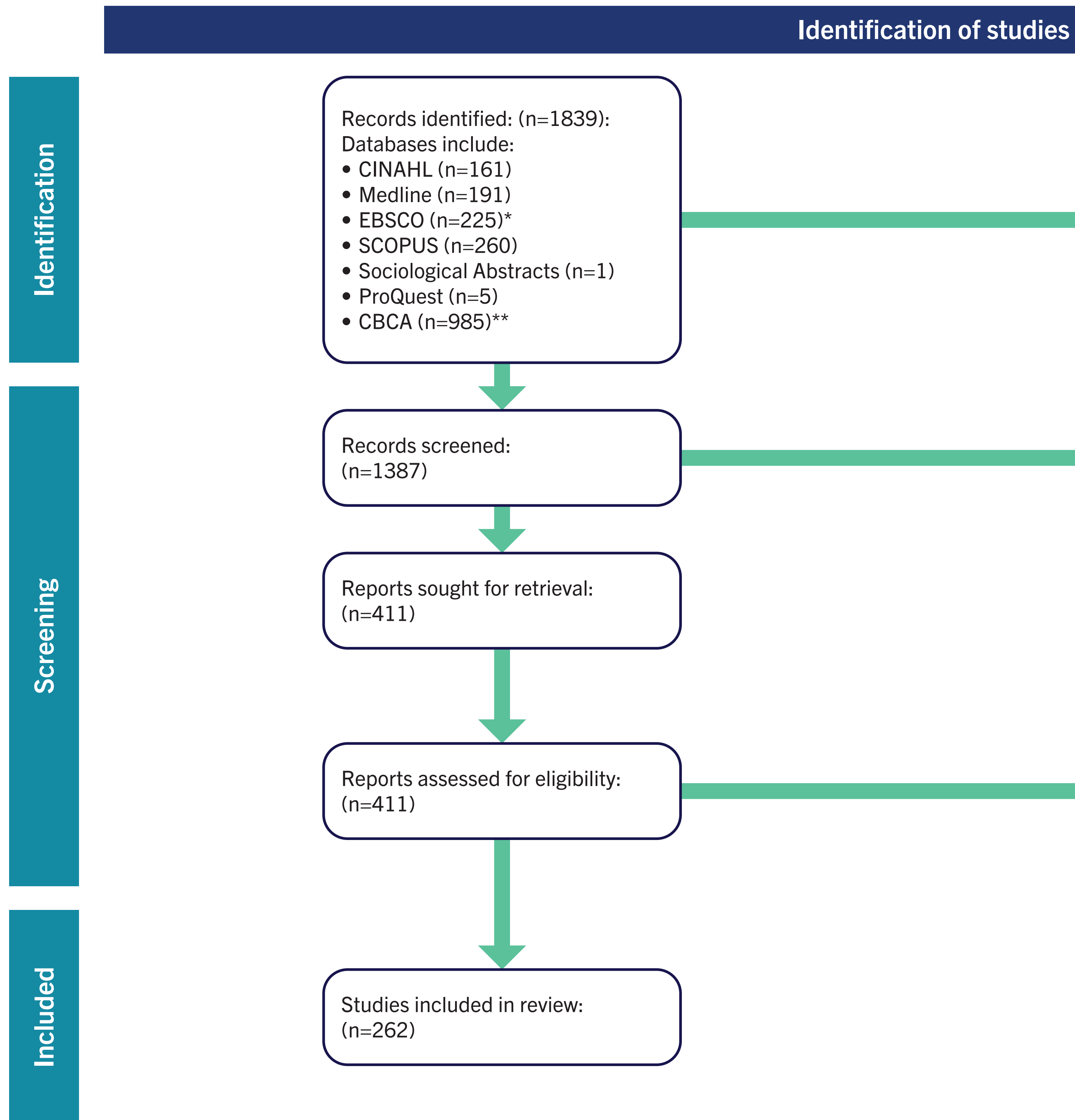
***Appendix I** – Flow diagram of included studies (Part 1)*



Note: *EBSCO = *PsychInfo (n = 422), *Academic Search Complete (n = 250), *America: History and Life (n = 10).
From: Page, J., McKenzie, J., Bossuyt, P., Boutron, I., Hoffmann, T., Mulrow, C., et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *British Medical Journal, 372*:n71. Doi: 10.1136/bmj.n71.


Identification of studies via other methods
Records identified from:
• Websites (n=0)
• Organisations (n=14)
• RPNAO (n=3)
• ONA (n=3)
• BCNU (n=7)
• Gov't of BC (n=1)
• Citation searching (n=9)
Reports sought for retrieval: (n=23)
Reports assessed for eligibility: (n=23)
Reports excluded: (n=8)
• Reason 1: Not about nurses' experiences of racism (n=6)
• Reason 2: Duplicate records (n=2)

Appendix II *– Flow diagram of included studies (Part 2)*



Note: EBSCO = PsychInfo (n = 38)*, Academic Search Complete (n = 186), America: History and Life (n = 1)** and Canadian Business & Current Affairs (CBCA). All studies and reports were identified from databases and registers.
From: Page, J., McKenzie, J., Bossuyt, P., Boutron, I., Hoffmann, T., Mulrow, C., et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *British Medical Journal, 372*:n71. Doi: 10.1136/bmj.n71.

via databases and registers

Records removed *before screening*:
- Duplicate records removed: (n = 0)
- Records marked as ineligible by automation tools: (n = 452)
- Records removed for other reasons: (n = 0)

Records excluded: (n=976)

Reports excluded
Reason 1: Did not meet inclusion criteria (n=144)
Reason 2: Duplicate (n=5)

Review #1 – Excluded Articles

1. (Agar-Newman, 1993) Agar-Newman, K. (1993). Let no one be silent. *Nursing BC / Registered Nurses Association of British Columbia, 25*(2).
   Exclusion reason: Wrong population
2. (Alarcon, 2018) Alarcon, V. (2018). Indigenous nurse calls for change. *Registered Nurse Journal, 30*(2), 8.
   Exclusion reason: Wrong population
3. (Allan, 2022). Allan, H. T. (2022). Reflections on whiteness: Racialised identities in nursing. *Nursing Inquiry, 29*(1), 1–9.
   Exclusion reason: Wrong location
4. (Allwright, 2018) Allwright, K. E. (2018). Testing a Cultural Humility Based Measurement Tool for Sexually and Gender Diverse Positive Spaces in Ontario Public Health Units [Master of Nursing Science, Queen's University]. In *ProQuest Dissertations and Theses* (Issue 13840583).
   Exclusion reason: Wrong population
5. (Auffrey, 2008). Auffrey, L. (2008). The value of professional recognition and positive practice environments. *The Canadian Nurse, 104*(3), 3.
   Exclusion reason: Nothing to extract
6. (Avery, 2001) Avery, R. (2001, August 6). Rejection still troubles nurse ; "It's hard for me to talk about it. It's over. I just want to live in peace." *Toronto Star,* A4.
   Exclusion reason: Wrong population
7. (Bains, 2020) Bains, C. (2020, July 9). Doctors, nurses urged to provide info on racism in B.C. emergency rooms. *The Canadian Press,* NA.
   Exclusion reason: Wrong population
8. (Baker et al., 2009) Baker, C., Varma, M., & Tanaka, C. (2009). Sticks and Stones: Racism as Experienced by Adolescents in New Brunswick: Perspectives en Nursing. *Canadian Journal of Nursing Research, 41*(1), 109.
   Exclusion reason: Wrong population
9. (Baldacchino et al., 2007) Baldacchino, G., Chandrasekere, S., & Saunders, P. (2007). Internationally educated health professions in Atlantic Canada. *Canadian Issues,* 104–107.
   Exclusion reason: Wrong population
10. (Barnsley, 2003). Barnsley, P. (2003). Mohawk graduate has uniquely Native problem. *Windspeaker, 21*(1), 33.
    Exclusion reason: Wrong population
11. (Bassendowski et al., 2006) Bassendowski, S., Petrucka, P., McBeth, B., & Smadu, M. (2006). Degrees of success: academic forum. Sihtoskatowin: "supporting one another" to build research capacity. *Minority Nurse,* 56–59.
    Exclusion reason: Wrong population
12. (Baxter, 2021) Baxter, D. (2021, June 23). Nurses demand progress on removing racism from health-care system. *The Canadian Press,* NA.
    Exclusion reason: Wrong population
13. (Belanger, 1997) Belanger, P. C. (1997). Abused women's experiences in support groups [Master of Nursing, University of Alberta]. In *ProQuest Dissertations and Theses* (Issue MQ21257).
    Exclusion reason: Wrong population
14. (Bennett, 2009) Bennett, D. (2009, January 13). Alberta College of Physicians drafting rules for new doctor code of conduct. *The Canadian Press,* NA.
    Exclusion reason: Wrong population
15. (Beunza et al., 1994) Beunza, I., Boulton, N., Ferguson, C., & Serrano, R. (1994). Diversity and commonality in international nursing. *International Nursing Review, 41*(2), 47–52, 56.
    Exclusion reason: Wrong population
16. (Bill & Gillis, 2018) Bill, L., & Gillis, L. (2018). Commentary: Indigenous Nursing - Learning from the Past to Strengthen the Future of Healthcare. *Nursing Leadership , 31*(1), 28–31.
    Exclusion reason: Wrong population
17. (Bissoondath, 1989) Bissoondath, N. (1989, February 11). 'I'm not racist but…'. *Toronto Star,* M13.
    Exclusion reason: Wrong population
18. (Blanchet Garneau et al., 2018). Blanchet Garneau, A., Browne, A. J., & Varcoe, C. (2018). Drawing on antiracist approaches toward a critical antidiscriminatory pedagogy for nursing. *Nursing Inquiry, 25*(1), 1.
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19. (Blanchfield, 2006) Blanchfield, C. (2006). Centre of excellence would support Aboriginal nursing students. *Canadian Nurse, 102*(4), 15–40.
    Exclusion reason: Wrong population

20. (Boamah, 2022) Boamah, S. A. (2022). The impact of transformational leadership on nurse faculty satisfaction and burnout during the COVID-19 pandemic: A moderated mediated analysis. *Journal of Advanced Nursing (John Wiley & Sons, Inc.),* 1.
Exclusion reason: Excludes racism/discrimination

21. (Bourque Bearskin, 2011) Bourque Bearskin, R. L. (2011). A critical lens on culture in nursing practice. *Nursing Ethics, 18*(4), 548–559.
Exclusion reason: Wrong population

22. (Bourque Bearskin, 2011). Bourque Bearskin, R. L. (2011). A critical lens on culture in nursing practice. *Nursing Ethics, 18*(4), 548–559.
Exclusion reason: Duplicate

23. (Braedley et al., 2018) Braedley, S., Owusu, P., Przednowek, A., & Armstrong, P. (2018). We're told, 'Suck it up': Long-Term Care Workers' Psychological Health and Safety. *Ageing International, 43*(1), 91–109.
Exclusion reason: Wrong population

24. (Bramadat & Saydak, 1993) Bramadat, I. J., & Saydak, M. I. (1993). Nursing on the Canadian prairies, 1900-1930. *Nursing History Review, 1,* 105–117.
Exclusion reason: Wrong population

25. (Briskin, 2012). Briskin, L. (2012). Resistance, mobilization and militancy: nurses on strike. *Nursing Inquiry, 19*(4), 285–296.
Exclusion reason: Wrong location

26. (Brockie et al., 2021) Brockie, T., Clark, T. C., Best, O., Power, T., Bourque Bearskin, L., Kurtz, D. L. M., Lowe, J., & Wilson, D. (2021). Indigenous social exclusion to inclusion: Case studies on Indigenous nursing leadership in four high income countries. *Journal of Clinical Nursing (John Wiley & Sons, Inc.),* 1.
Exclusion reason: Wrong population

27. (Brown et al., 2012). Brown, H. J., McPherson, G., Peterson, R., Newman, V., & Cranmer, B. (2012). Our Land, Our Language: Connecting Dispossession and Health Equity in an Indigenous Context: Perspectives en Nursing. *Canadian Journal of Nursing Research, 44*(2), 1.
Exclusion reason: No racism/discrimination

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Exclusion reason: Wrong population

29. (Browne et al., 2002b) Browne, A. J., Johnson, J. L., Bottorff, J. L., Grewal, S., & Hilton, B. A. (2002b). Recognizing discrimination in nursing practice. *Canadian Nurse, 98*(5), 24–27.
Exclusion reason: Wrong setting

30. (Browne et al., 2009) Browne, A. J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy, 10*(3), 167–179.
Exclusion reason: Excludes racism/discrimination

31. (Bruce, 1996) Diversity in nursing has its merits. *Nursing BC / Registered Nurses Association of British Columbia, 28*(2), 4–5.
Exclusion reason: Excludes racism/discrimination

32. (Brunton et al., 2019) Brunton, M., Cook, C., Kuzemski, D., Brownie, S., & Thirlwall, A. (2019). Internationally qualified nurse communication—A qualitative cross country study. *Journal of Clinical Nursing, 28*(19/20), 3669–3679.
Exclusion reason: Wrong setting

33. (Bunner, 1994) Bunner, K. L. (1994). Human rights and implications for managers. *Canadian Journal of Nursing Administration, 7*(2), 22–37.
Exclusion reason: Excludes racism/discrimination

34. (Butler et al., 2018) Butler, L., Exner-Pirot, H., & Berry, L. (2018). Reshaping Policies to Achieve a Strategic Plan for Indigenous Engagement in Nursing Education. *Nursing Leadership,* 31(1), 18–27.
Exclusion reason: Wrong population

35. (Calliste, 1993). Calliste, A. (1993). Women of "exceptional merit": immigration of Caribbean nurses to Canada (1950-1962). *Canadian Journal of Women and the Law,* 6(1), 85–102.
Exclusion reason: Duplicate

36. (Canada NewsWire, 2003) Canada NewsWire. (2003, June 12). Outcome of Mediation of Ontario's Pay Equity Charter challenge. *Canada NewsWire,* 1.
Exclusion reason: Wrong population

37. (Canada NewsWire, 2007) Canada NewsWire. (2007, August 28). Ontario Nurses' Association Lifts Censure: ONA and University Health Network Working Together to Improve Labour Relations. *Canada NewsWire,* 1.
Exclusion reason: Excludes racism/discrimination

38. (Canada NewsWire, 2008) Canada NewsWire. (2008, July 21). ONA, Hotel-Dieu Grace Hospital Resolve Grievance. *Canada NewsWire,* NA
Exclusion reason: Wrong population

39. (Canada NewsWire, 2011a). Canada NewsWire. (2011, April 25). Experts Examine Solutions to Canada's Nursing Shortage with Internationally Educated Nurses. *Canada NewsWire,* NA.
Exclusion reason: Nothing to extract

40. (Canada NewsWire, 2011b) Canada NewsWire. (2011b, June 3). Arbitration Award Affecting Ontario's Hospitals and Registered Nurses Released. *Canada NewsWire,* NA.
Exclusion reason: Excludes racism/discrimination

41. (Canada NewsWire, 2014) Canada NewsWire. (2014, November 1). Guelph Community Health Centre Nurses Need Your Support. *Canada NewsWire,* NA.
Exclusion reason: Excludes racism/discrimination

42. (Canada NewsWire, 2015) Canada NewsWire. (2015, April 28). Nurses insist on accountable action following First Nations health report. *Canada NewsWire,* NA.
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43. (Canadian Employment Law Today, 2013) Canadian Employment Law Today. (2013, February 20). Workers Compensation: Stress claim dismissed, accepted, dismissed again. *Canadian Employment Law Today,* 7.
Exclusion reason: Wrong population

44. (Canadian Employment Law Today, 2018) Canadian Employment Law Today. (2018, March 28). You make the call. *Canadian Employment Law Today,* 12.
Exclusion reason: Wrong population

45. (Canadian HR Reporter, 2003) Canadian HR Reporter. (2003, February 24). Danger claim must be proven. *Canadian HR Reporter, 16*(4), 9.
Exclusion reason: Excludes racism/discrimination

46. (Canadian NewsWire, 2021) Canadian NewsWire. (2021, October 14). Supreme Court of Canada Denies Ford Government and Nursing Homes' Attempt to Block Pay Equity Access for Women Working in Healthcare. *Canada NewsWire,* NA.
Exclusion reason: Wrong population

47. (Canadian NewsWire, 2022) Canadian NewsWire. (2022, February 24). Canadian Nurses Foundation launches the TYLENOL® Fund to Advance Diversity in Nursing and Health Equity Research for Black, Indigenous and People of Colour. *Canada NewsWire,* NA.
Exclusion reason: Wrong population

48. (Canadian Nurse, 2007). Canadian Nurse. (2007). Perspectives. Aboriginal nursing program benefits from new funding. *Canadian Nurse, 103*(8), 6.
Exclusion reason: Wrong population

49. (Canadian Nurse, 2009a) Canadian Nurse. (2009a). Inuit nurses to know. *Canadian Nurse, 105*(5), 21.
Exclusion reason: Excludes racism/discrimination

50. (Canadian Nurse, 2009b). Nursing in Nunavut. (2009). *Canadian Nurse, 105*(5), 16–19.
Exclusion reason: Excludes racism/discrimination

51. (Canadian Nurse, 2009b). Nursing in Nunavut. (2009). *Canadian Nurse, 105*(5), 16–19.
Exclusion reason: Duplicate

52. (Canadian Nurse, 2010) Canadian Nurse. (2010). Taking action on gender equity. *Canadian Nurse, 106*(9), 21.
Exclusion reason: Excludes racism/discrimination

53. (Canadian Nurse, 2011) Canadian Nurse. (2011). A head start on recruiting Inuit nurses. *Canadian Nurse, 107*(5), 5.
Exclusion reason: Wrong population

54. (Canadian Nurse, 2012) Canadian Nurse. (2012). "A dream job". *Canadian Nurse, 108*(2), 34–36.
Exclusion reason: Excludes racism/discrimination

55. (Canadian Nurses Association, 2018) Canadian Nurses Association. (2018). Priorities and partnerships in Indigenous nursing...Marilee Nowgesic. *Canadian Nurse, 114*(3), 26–29.
Exclusion reason: Excludes racism/discrimination

56. (Canadian Press NewsWire, 1995) Canadian Press NewsWire. (1995, December 3). Quebec may soon face another anglo exodus. *Canadian Press NewsWire,* NA.
Exclusion reason: Wrong population

57. (Capell et al., 2008) Capell, J., Dean, E., & Veenstra, G. (2008). The relationship between cultural competence and ethnocentrism of health care professionals. *Journal of Transcultural Nursing, 19*(2), 121–125.
Exclusion reason: Excludes racism/discrimination

58. (Carrier, 2015). Carrier, M. (2015). Rôle de l'infirmière en milieu autochtone isolé. *Perspective Infirmiere, 12*(2), 18.
Exclusion reason: No racism/discrimination

59. (Carroll, 2018) Carroll, J. M. (2018). Cultural Humility and Transgender Clients: A Study Examining the Relationship between Critical Reflection and Attitudes of Nurse Practitioners [Master of Nursing Science, Queen's University]. In *ProQuest Dissertations and Theses* (Issue 10999622).
Exclusion reason: Wrong population

60. (Carter et al., 2017) Carter, C., Lapum, J., Lavallée, L., Schindel Martin, L., & Restoule, J.-P. (2017). Urban First Nations Men: Narratives of Positive Identity and Implications for Culturally Safe Care. *Journal of Transcultural Nursing, 28*(5), 445–454.
Exclusion reason: Wrong population

61. (Cartwright, 2006) Cartwright, J. (2006, October). Building Bonds of Solidarity. *Our Times, 25*(5), 21–23.
Exclusion reason: Wrong population

62. (Chaudhri, 2016) Chaudhri, S. (2016). Ontario's new creed. *Canadian Employment Law Today,* 4–5.
Exclusion reason: Wrong population

63. (Chronicle - Herald, 1998) Chronicle - Herald. (1998, March 19). Doctors support workers' bid for pay equity.
Exclusion reason: Excludes racism/discrimination

64. (Clarke, 1997) Clarke, H. F. (1997). Research in Nursing and Cultural Diversity: Working with First Nations Peoples. *Canadian Journal of Nursing Research, 29*(2), 11–25.
Exclusion reason: Wrong setting

65. (Clarke et al., 2012) Clarke, C. M., Kane, D. J., Rajacich, D. L., & Lafreniere, K. D. (2012). Bullying in Undergraduate Clinical Nursing Education. *Journal of Nursing Education, 51*(5), 269–276.
Exclusion reason: Wrong population

66. (Clow & Ricciardelli, 2011). Clow, K. A., & Ricciardelli, R. (2011). Women and men in conflicting social roles: Implications from social psychological research. *Social Issues and Policy Review, 5*(1), 191–226.
Exclusion reason: Wrong location

67. (Clow et al., 2014) Clow, K. A., Ricciardelli, R., & Bartfay, W. J. (2014). Attitudes and Stereotypes of Male and Female Nurses: The Influence of Social Roles and Ambivalent Sexism. *Canadian Journal of Behavioural Science, 46*(3), 446–455.
Exclusion reason: Wrong population

68. (Clow et al., 2015). Clow, K., Ricciardelli, R., & Bartfay, W. (2015). Are You Man Enough to be a Nurse? The Impact of Ambivalent Sexism and Role Congruity on Perceptions of Men and Women in Nursing Advertisements. *Sex Roles, 72*(7–8), 363–376.
Exclusion reason: Wrong population

69. (Corsini et al., 2019) Corsini, E. M., Luc, J. G. Y., Mitchell, K. G., Turner, N. S., Vaporciyan, A. A., & Antonoff, M. B. (2019). Predictors of the response of operating room personnel to surgeon behaviors. *Surgery Today, 49*(11), 927–935.
Exclusion reason: Wrong setting

70. (Courtenay et al., 2005) Courtenay, M., Care, W. D., Gregory, D., Hultin, D., & Russell, C. (2005). Appendix 4 -- Seeking cultural competence: Aboriginal nursing students' experiences with distance technology. *Aboriginal Nurses Association of Canada Annual Conference Held September 15 & 16, 2005: "Building Cultural Competence in Nursing Through Traditional Knowledge: Our 30-Year Journey,"* 36–39.
Exclusion reason: Wrong population

71. (CTV National News, 2021) CTV National News. (2021, March 16). Two Nurses Fired For Racism In Quebec. *CTV National News - CTV Television,* NA.
Exclusion reason: Wrong population

72. (Curran et al., 2008) Curran, V., Solberg, S., LeFort, S., Fleet, L., & Hollett, A. (2008). A responsive evaluation of an Aboriginal nursing education access program. *Nurse Educator, 33*(1), 13–17.
Exclusion reason: Wrong population

73. (Darroch et al., 2017). Darroch, F., Giles, A., Sanderson, P., Brooks-Cleator, L., Schwartz, A., Joseph, D., & Nosker, R. (2017). The United States does CAIR about cultural safety: Examining cultural safety within Indigenous health contexts in Canada and the United States. *Journal of Transcultural Nursing, 28*(3), 269–277.
Exclusion reason: Wrong context

74. (De Sousa & Varcoe, 2022) De Sousa, I., & Varcoe, C. (2022). Centering Black feminist thought in nursing praxis. *Nursing Inquiry, 29*(1), 1–10.
Exclusion reason: Wrong setting

75. (Desrosiers, 2006) Desrosiers, G. (2006). A great get-together in 2006. *Perspective Infirmière : Revue Officielle de l'Ordre Des Infirmières et Infirmiers Du Québec, 3*(3), 6–9.
*Exclusion reason:*Excludes racism/discrimination

76. (Dionne-Proulx, 1994). Dionne-Proulx, J. (1994). AIDS: patients' rights, professional risks, preventive measures. *The Canadian Nurse, 90*(10), 43–47.
Exclusion reason: No racism/discrimination

77. (Dobbelsteyn, 2006) Dobbelsteyn, J. L. (2006). Nursing in First Nations and Inuit communities in Atlantic Canada. *Canadian Nurse, 102*(4), 32–35.
Exclusion reason: Excludes racism/discrimination

78. (Dokis, 2005). Indigenous nursing knowledge - Finding our voice through sharing. *Aboriginal Nurses Association of Canada Annual Conference. Nursing Through Traditional Knowledge,* 17–17.
Exclusion reason: Nothing to extract

79. (Donkoh, 1997) Donkoh, S. (1997, June 19). Women taking OHRC to court. *Share, 11,* 1, 8.
Exclusion reason: Wrong population

80. (Douma, 2017) Douma, M. (2017). What makes a difference? *British Journal of Nursing, 26*(21), 1150.
Exclusion reason: Excludes racism/discrimination

81. (Downey, 2003) Downey, B. (2003). Inaugural international Indigenous nurses and midwives caucus. *The Aboriginal Nurse, 18*(2), 10–12.
Exclusion reason: Excludes racism/discrimination

82. (Downey, 2005) Downey, B. (2005). Understanding the context of cultural competency and cultural safety in the recruitment, retention, training and utilization of First Nations, Inuit and Métis in the nursing profession. *Aboriginal Nurses Association of Canada Annual Conference Held September 15 & 16, 2005: "Building Cultural Competence in Nursing Through Traditional Knowledge: Our 30-Year Journey,"* 6.
Exclusion reason: Wrong population

83. (Dywili et al., 2012) Dywili, S., Bonner, A., Anderson, J., & O' Brien, L. (2012). Experience of overseas-trained health professionals in rural and remote areas of destination countries: A literature review. *Australian Journal of Rural Health, 20*(4), 175–184.
Exclusion reason: Wrong population

84. (Edgecombe, 1998) Edgecombe, N. A. (1998). Value orientation of the Copper Inuit. *International Journal of Circumpolar Health, 57 Suppl 1,* 55–61.
Exclusion reason: Wrong population

85. (Endicott, 2006) Endicott, L. (2006, February). You Carry My Heart. *Our Times, 25*(1), 2.
Exclusion reason: Wrong population

86. (Ervin & Pierangeli, 2005) Ervin, N. E., & Pierangeli, L. T. (2005). The concept of decisional control: Building the base for evidence-based nursing practice. *Worldviews on Evidence-Based Nursing, 2*(1), 16–24.
Exclusion reason: Wrong population

87. Etowa, J. (2005). Surviving on the margin of a profession: Experiences of Black nurses. [Doctor of Philosophy, University of Calgary]. In *Surviving on the Margin of a Profession: Experiences of Black Nurses* (Issue Ph.D.).
Exclusion reason: Duplicate

88. Etowa, J., Foster, S., Vukic, A. R., Wittstock, L., & Youden, S. (2005). Recruitment and retention of minority students: diversity in nursing education. *International Journal of Nursing Education Scholarship, 2*(1), 12p–12p.
Exclusion reason: Wrong population

89. (Etowa et al., 2011). Etowa, J., Matthews, V., Vukic, A., & Jesty, C. (2011). Uncovering Aboriginal Nursing Knowledge through Community Based Participatory Research. *Indigenous Policy Journal, XXII*(1), 1–16.
Exclusion reason: Wrong context

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Review #2 – Excluded Articles

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2. (Checkland et al., 2021). Checkland, C., Benjamin, S., Bruneau, M.-A., Cappella, A., Cassidy, B., Conn, D., Grief, C., Keng, A., Kirkham, J., Krishna, P., McMurray, L., Rabheru, K., Tourigny-Rivard, M.-F., & Seitz, D. P. (2021). Position Statement for Mental Health Care in Long-Term Care During COVID-19. *Canadian Geriatrics Journal, 24*(4), 367–372.
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32. (Toronto Star, 2022). Toronto Star. (2022, May 24). Ontario running short on nurses: Estimated 10% of hospital RN spots are vacant with a provincial deficit of over 20,000 positions. *Toronto Star,* A7.
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33. (Canada NewsWire, 2022b). Canada NewsWire. (2022b, May 16). Physicians, nurses offer solutions to immediately address health human resource crisis. *Canada NewsWire,* NA.
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Exclusion reason: Wrong population

35. (The Canadian Press, 2022). The Canadian Press. (2022, February 8). Canadian Red Cross sends six nurses to Nunavut for worst outbreak of COVID-19. *The Canadian Press,* NA.
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Exclusion reason: Wrong concept

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Exclusion reason: Wrong concept

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Exclusion reason: Wrong concept

49. (Ferguson, 2021). Ferguson, R. (2021, November 28). Ontario to hire 2,000 more nurses: Province setting aside $100M to boost staffing, care in nursing homes. *Toronto Star,* A2.
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50. (McKenzie-Sutter, 2021). McKenzie-Sutter, H. (2021, November 27). Ontario aims to add 2,000 more nurses in long-term care sector. *The Canadian Press,* NA.
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Exclusion reason: Wrong population

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Exclusion reason: Wrong concept

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Exclusion reason: Wrong concept

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Exclusion reason: Wrong concept

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68. (Taylor, 2020). Taylor, S. (2020, November 16). Saskatchewan nurses union wants shutdown; premier considers more COVID-19 measures. *The Canadian Press,* NA.
Exclusion reason: Wrong concept

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Exclusion reason: Wrong population

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Exclusion reason: Wrong concept

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Exclusion reason: Wrong population

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Exclusion reason: Wrong concept

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Exclusion reason: Wrong concept

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