Student Perspectives on Preparation to be Just and Socially Responsible Providers: A Northwestern Ontario Qualitative Case Study

by

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Author's Declaration of Originality

I hereby declare that I am the sole author of this thesis.

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Abstract

There is increasing recognition of the need to create just and socially responsible healthcare providers (HCP). Such recognition is evidenced by health professions training programs' accreditation standards and expected competencies, as well as calls to action from the World Health Organization (WHO) (WHO, 2021, p. 25; WHO, 2022, p. 21), United Nations Sustainable Development Goals (2015) and, specifically in Canada, the calls to action from the Truth and Reconciliation Commission of Canada (including: 23iii, and 24 which deal with health professions education, and 44 relating to the actualizing of the *United Nations Declaration on the Rights of Indigenous Peoples*). Such calls to action are the result of health gaps between populations and instances of racism reported throughout the healthcare system. For example, in recent years discrimination and racism within the healthcare system has resulted in very evident consequences such as the premature death of Joyce Echaquan in 2020 (Nerestant, 2021). This study looked at the effectiveness of post-secondary curriculum and initiatives in preparing health professions students to work in a safe and equitable manner with diverse populations in response to these calls to action. While much work has been done investigating the use of social accountability (SA) within undergraduate medical education (UME), there is a need to explore SA as well as other initiatives across the health professions and how this contributes to student uptake of social responsibility and social justice (SRSJ).This work utilized a qualitative case study methodology to examine students' experiences with and perceived preparedness to act on SRSJ-related curriculum within and across two post-secondary institutions in northwestern Ontario (NWO). Analysis resulted in the following themes: those across the Lakehead University case (*preparation is a patchwork*; *the theory to practice gap*; *(un)supportive learning environment*; *contextualizing the curriculum to place and practice*; *superficiality*; *front-loading*

of didactic material; *instructor identities influence learning*) and those across the Confederation College case (*preparation is a patchwork*; *inherent (de)valuing of just and socially responsible care concepts*; *contextualizing the curriculum to place*; *superficiality*; *varied didactic styles, varied outcomes*; *instructor identities influence learning*). Such findings give way to considerations to promote SRSJ among health professions students. For the Lakehead University case these included: *committing to promoting just and socially responsible practice particularly within the health professions; establishing space and systems of support for students challenging non SRSJ behavior within the learning environment; diversifying the learning environment.* For the Confederation College case these included: *valuing SRSJ concepts in practice; increasing students' exposure to just and socially responsible care concepts; establishing a commitment to promoting just and socially responsible practice.* Data presented here has the potential to help support programmatic efforts to more fully include SRSJ in health professions programs to help prepare just and socially responsible providers not solely in NWO, but in similar regions where heterogeneous populations reside.

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Introduction

According to the 2015 United Nations Sustainable Development Goals, good health and well-being are a priority globally and to be achieved by the year 2030 (United Nations, 2015). However, challenges to health and well-being and overall health equity continue to be seen. Such challenges to equity and access, can be influenced by peoples' interactions with and perceptions of healthcare systems and workers (Rivenbark & Ichou, 2020). For example, run-ins with unsafe care may result in exacerbated health gaps and continued health inequity. Recently several reports of racism and discrimination within Canadian healthcare systems have caught the attention of both national and international media (see: Fraser, 2021; Geary, 2017; Nerestant, 2021). Furthermore, during the COVID-19 pandemic, it was found that those who were already socioeconomically-disadvantaged, were at increased risk of direct impacts related to the pandemic (i.e. illness and death) (Government of Canada, 2020). More locally, research has found that a third of "adults in Thunder Bay reported that they were treated unfairly by healthcare providers (HCPs) because of their Indigenous identity" and "66% of Indigenous adults who reported experiencing racism from HCPs said it prevented, stopped or delayed them from returning to health services" (Brar et al., 2020, p. 1). Additionally, findings such as those noted by Alzghoul et al. (2021) indicate that inequitable care is directed towards non-Indigenous clients as well within this region, including other visible minorities such as the growing Muslim population.

Not only is racism[1] and discrimination a challenge, the health gap between Indigenous and non-Indigenous populations as well as between Euro-Canadians and Black, Indigenous and

[1] Racism may take on many different forms—internalized, interpersonal, institutional and structural racism, all of which can and may appear in healthcare settings. Racial discrimination as defined by the United Nations Association of Canada is "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an

People of Colour (BIPOC) populations living in Canada is stark (see: Public Health Agency of Canada, 2018), and health discrepancies also exist between the different Indigenous populations within Canada that are recognized by the Canadian government[2]: First Nations, Inuit and Métis (Public Health Agency of Canada, 2018).

People described as marginalized[3] are often grouped together, although the experiences that have led to said marginalization are very different. Indigenous Peoples have unique experiences with the colonial state[4] (as compared to others within the state) leading to particular impacts on Indigenous Peoples' way of life and ultimately health (see: Allan & Smylie, 2015; Schiff & Møller, 2021). The health discrepancies between the overall Canadian population and Indigenous peoples in Canada and other Canadians who are systematically marginalized (including Black Canadians, other People of Colour in Canada and people from other groups experiencing marginalization) should be evaluated differently and considered within their separate contexts (Public Health Agency of Canada, 2018, p. 7; Tuck & Yang, 2012). As Black Canadian scholar and writer Robyn Maynard (2019) writes, while Indigenous Peoples across Turtle Island experience the everyday impacts of colonization and continued colonialism, other marginalized populations such as Black people and refugees experience the effects of the same colonialism in the form of imposed immigration policies, international borders and potential

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equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life". For more information on the forms of racism, the Multicultural Association of Saskatchewan has a resource page: https://mcos.ca/programs/anti-racism/resources/ .

[2] It should be stated that while these three Indigenous groups are those that are recognized by the Canadian government, as Bearskin et al. (2016) note, some Indigenous peoples prefer to identify as part of their linguistic group (e.g. Cree).

[3] To marginalize is to treat someone or something as if they are not important (Cambridge Dictionary, n.d.). According to the International Institute for Sustainable Development "marginalization puts people at disproportionate health, social, and economic risks when a disaster strikes—such as a pandemic or a major climate impact" (Jungcurt, 2022).

[4] The colonial state refers to land that is geographically separated from the colonizing "mother" country, but is occupied by members of the mother country, often to enforce rules and regulations. As Tuck & Yang (2010) state, "the horizons of the settler colonial nation-state are total and require a mode of total appropriation of Indigenous life and land, rather than the selective expropriation of profit-producing fragments" (p. 5).

displacement or incarceration. Thus, while the experience of the colonial state is different for each population, there is "a critical site for solidarity" due to both Black and Indigenous populations' "inability to exist, free from violence, within the boundaries of citizenship of the United States or Canada" (Maynard, 2019, p. 141).

In addition to the implications stemming from ongoing manifestations of colonialism: racism, stereotyping of health trends, (Allan & Smylie, 2015), absence of self-determination (Public Health Agency of Canada, 2018), it is important to understand the role that globalization plays in Canada and how globalization affects current health trends. A shift in immigration from predominantly European countries to African and Asian countries (see: Ontario Ministry of Finance, 2016), may give rise to new and or increased health disparity trends between immigrants and non-immigrant Canadians and between Euro-Canadians and Canadians of diverse cultural and racial backgrounds (see: Public Health Agency of Canada, 2018). A study published in 2021, found that "[i]n comparison to racialized immigrants, Canadian-born whites, and white immigrants both had approximately 35% higher odds of good self-reported health, even when statistical adjustments were made for a wide range of demographic, socioeconomic, social engagement, and social support variables" (McAlpine et al., 2021, p. 13). Furthermore, given multiple studies that indicate poor self-perceived health among non-White and other marginalized populations in Canada (Abdillahi & Shaw, 2020; Cloos et al., 2020; Du Mont & Forte, 2016; New Brunswick, 2016), there is an ongoing trend of a severe and persistent health gap, and personal experience and voice must not be taken away from the consideration of this health gap. As Indigenous nurse scholar Mae Katt says in reference to the turmoil caused by compounding rates of suicide in the Nishnawbe Aski Nation, "how do you capture that in a statistic?" (Health Quality Ontario, 2017). Analyzing the health gap through the lens of cultural

competency[5] (CC) without considering non-clinical factors or social determinants of health (SDOH) and personal bias, practitioners and educators may see the individual as the main contributor (both positively and negatively) to their own health, leading to harmful perpetuation of stereotypes (see: Public Health Agency of Canada, 2018, p. 7). This is especially the case with Indigenous health statistics which have largely been "deficit-based" and often not contextualized within the legacy of colonization and continued colonialism which have caused them (Public Health Agency of Canada, 2018, p. 7).

Historically, following a positivist paradigm (Brown & Dueñas, 2019), health inequities have been conceptualized as the effect of individual health behaviors (Glouberman & Millar, 2003). This has pushed aside the consideration of other significant determinants of health and systemic barriers that create disparities among vulnerablized and marginalized populations such as those with different gender or sexual orientations, women, seniors, people with disabilities, BIPOC individuals, and people living with low socioeconomic status (see: Public Health Agency of Canada, 2018). Additionally, a systems-based approach to analyzing health inequities is vital to understanding the entrenched layers of discrimination that create barriers and thus further marginalize particular populations. For example, when considering the health gap between BIPOC and euro-centric Canadians, or even between Indigenous and marginalized settler Candian populations, it is important to consider the structural determinants of health.[6] Such structural determinants of health are often covert, working on an unseen level to influence health outcomes (often negatively). Examples of structural determinants include but are not limited to

[5] The topic of Cultural Competency is discussed at length in the Background subsection entitled "Cultural Competency"; see page 24.

[6] The structural determinants of health are those which contribute to "the unequal distribution of health-damaging" consisting "of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries" (WHO, 2008, p. 1) These structural determinants also consist of social norms and values (Government of Canada, 2020).

discrimination in its many forms (racism, ableism, ageism, etc.) as well as colonial policies such as the Indian Act (Richmond & Cook, 2016), immigration-related policies (Maynard, 2019) and access to resources such as housing (Government of Canada, 2020).

To prevent racism and discrimination, promote equity and social justice, and train HCPs to be just and socially responsible, programs and educators working in the health professions have turned their attention to learning about the identities and contexts that compose their diverse community populations. Historically this has included placing a focus on multicultural education and cultural competence education in various health professions programs (see: Association of American Medical Colleges, 2005; Global Consensus for Social Accountability of Medical Schools, 2010; Gustafson & Reitmanova, 2010; Rowan et al., 2013; Wilson et al., 2020). More recently a move towards more cultural safety (defined as "allow[ing] the recipient of care to say whether or not the service is safe for them to approach and use" (Ramsden, 2002, p. 6)), and humility (defined as "de-emphasiz[ing] cultural knowledge and competency and plac[ing] greater emphasis on lifelong nurturing of self-evaluation and critique, promotion of interpersonal sensitivity and openness, addressing power imbalances, and advancement of an appreciation of intracultural variation and individuality to avoid stereotyping (Stubbe, 2020, p. 50) has been seen (see: Lokugamage & Marya, 2023; Webb et al., 2023). Other efforts have included the use of social accountability (SA) as a framework to allow institutions to fulfill "the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve" (Boelen & Heck, 1995).

If the goal of the healthcare system and the care providers within it is to work towards health equity, a common definition of what is needed to create just and socially responsible providers might be a good place to start– the concepts and frameworks mentioned provide some

of that direction. However, to better understand the current context of health professions education, these common concepts and frameworks are explored further throughout the background section and literature review.

The focus of this thesis is to explore whether students in health professions programs feel prepared to work towards health equity upon graduation, through a lens of social responsibility and social justice (SRSJ) for their surrounding communities. The terms "just and socially responsible" used throughout this study encompass a larger idea that includes a practice of working on multiple different concepts to reach the same goal– care that has a social justice orientation and that which is socially responsible or working towards the common good according to what communities and patients require to attain good health. Within this are the common ideas and concepts of Cultural Safety (CS), Cultural Competency (CC), social justice, social accountability to name a few. These concepts are elaborated on in Tables 1 and 2.

Given that physicians, nurses and paramedics are those that people typically encounter when accessing healthcare, these are the focus of this thesis. To inform this work, in the background section I describe the professional competencies, accreditation standards, and regulations that according to the literature, govern the practice of these HCPs. Following this, I present a comprehensive literature review that outlines the typical concepts and frameworks used in health professions education. Thereafter the research setting, methodology, containing my positionality, research ontology and epistemology, setting considerations and study design, as well as the results, discussion and considerations follow.

Background

With the evolution of health and the finding of new obstacles and new cures, definitions of health also change (for example, see: Blaxter, 2010; Huber et al., 2011; First Nations Health

Authority, First Nations Perspective on Health and Wellness section, n.d.; World Health Organization [WHO], 1946). Along with this, healthcare professions evolve to adapt to these new definitions, with an emphasis on changing what future HCPs are learning before stepping into their careers. In the 1970s, with the publishing of the Lalonde Report (1974), one of the biggest changes to the Canadian concept of health occurred, with a shift towards understanding and acting upon the Social Determinants of Health (SDOH), something that is now widely discussed in healthcare, health education, and policy alike. Already preceding this document, the World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, indicating that social factors have been implicated in health for much longer than the healthcare system has recognized (1946, p. 2). Yet, despite how thought-provoking and innovative the Lalonde Report was for its time, it has since received ample critique for its focus on individual health behaviours rather than the social factors that more predominantly contribute to health outcomes (Galvin, 2002; Glouberman & Millar, 2003; Holland, 2014, ch. 6; Veatch, 1980). Following this report, the relevance and importance of the SDOH was established through the introduction of a permanent health promotion policy and program (the Health Promotion Directorate) by the Canadian government– leading to many initiatives to promote health within varying social environments (i.e. schools, workplaces, and communities) (Glouberman & Millar, 2003). Then in 1984, a more critical document was published, the Epp report, written by then Minister of Health and National Welfare, Jake Epp (Epp, 1986). Epp went a bit further than Lalonde’s simple acknowledgement of the SDOH and suggestions for policy development and introduced a new definition of health. Epp defined health as immeasurable “strictly in terms of illness and death. It becomes a state which individuals and communities alike strive to achieve, maintain or regain, and not something

that comes about merely as a result of treating and curing illnesses and injuries. It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments" (Epp, 1986, para. 6). In the same year, the first International Conference on Health Promotion took place as a collaboration between the WHO and the Canadian Public Health Association (CPHA) in Ottawa, resulting in the Ottawa Charter for Health Promotion. This written report has become a seminal document in the Public Health field, guiding health professionals to look outside of individual behaviors as the sole contributors to health, and to begin to promote health within the social sphere to reach health equity (i.e. advocating for peace, social stability, housing, etc.) (World Health Organization, 1986).

After the establishment of the SDOH as a legitimate public health concern, the priority shifted to addressing the SDOH in practice as purported by Glouberman & Millar (2003). Yet health disparities continued to exist, resulting in new concepts, such as cultural competence (CC), being introduced to address the discrepancies in health and provision of appropriate and timely healthcare seen between marginalized and non-marginalized groups (see: Aboriginal Nurses Association of Canada, 2009; Association of American Medical Colleges, 2005; Gallegos et al., 2008; Rowan et al., 2013). However, despite the focus on CC and addressing cultural differences, health discrepancies continued to exist, thus health faculties across Canada and the world began to adopt SRSJ-related mandates and corresponding curriculum that fulfills these mandates early in the 2000s (see: Health Canada, 2001).

SRSJ-related curriculum that has taken up more space in health professions education over the past decade includes CC, CS, cultural humility, critical consciousness, SDOH, intersectionality, global health, social justice, and health advocacy. Among accrediting and regulatory bodies, these terms may or may not be the focus of curriculum and practice and may

also be defined or conceptualized differently. Alongside these, various frameworks and lenses for teaching SRSJ-related content may be seen. These concepts, frameworks and lenses are described in Tables 1 and 2 and expanded upon in the literature review.

Table 1

Frameworks & Lenses within SRSJ Curriculum

Frameworks & Lenses	Definitions/Implications
Social Accountability (SA)	In the WHO's *Defining and measuring the social accountability of medical schools* document, SA is defined as the obligation to modify education, research, and service to align with the needs of the community with which one works (Boelen & Heck, 1995). Hammond et al. (2019) diversifies accountability into various forms of "answerability … for identifying and removing obstacles and barriers to health equity, through a complex ongoing process that engages multiple actors at different points on the circle of accountability" (p. 2). This same sentiment is echoed in the *Global consensus for social accountability of medical schools* (2010) wherein 10 priority directions are identified for ensuring SA of medical schools. These directions include but are not limited to: partnering with both the health system and stakeholders (community members and other constituents), anticipating the needs of society, and preparing students to be competent and flexible future physicians who can adapt to the ever-changing needs of society. This last point specifically is mentioned in tandem with a need for socially-accountable future physicians to be taking a population health lens to their work and to actively participate in health-related advocacy and reform. Thus, there is an expectation that health professionals are able to identify and help mitigate barriers to health equity.
Critical Cultural Approach	The underpinnings of this approach include "understanding culture as a complex, shifting, relational process", "recognizing that popular views of culture, which conflate culture with ethnicity and race, dominate western thinking and promote racialization" and "understanding that culture is enacted relationally… we all participate in and create culture for different purposes and have choices regarding how we do so" (Browne & Varcoe, 2006, p. 162). It has also been described to include: "cultural responsiveness", "anti-racist pedagogy", "critical consciousness", and to impart knowledge relating to power inequities, as well as the sources of health inequalities– looking at the "historical and political context of health and healthcare delivery" as well as SDOH (Reitmanova, 2011, Table 1, p.199). Reitmanova (2011) indicates that skills acquired through this approach should be focused less on identifying "facts" about different cultural or ethnic groups, and more on "eliciting the relevance of race, ethnicity, religion, class, gender, etc., to patient health" (Table 1, p. 199). Essentially, this approach takes a more critical stance in pointing out that knowledge of what culture is, is constructed in everyday interactions (i.e. social constructivist epistemology); knowledge, contrary to what the biomedical model are by some described as preaching, is not always objective and fact-based (Gustafson & Reitmanova, 2010). It also focuses on raising awareness of the HCP's positionality and inherent power as a HCP, rather than on tolerating, including, and appreciating the "other" (Reitmanova, 2011). Again, instead of a competency to be achieved, the Critical Cultural approach focuses on refinement of a HCP's skills in self-evaluation, critical reflection, and a commitment to always reflecting on power imbalances and how to lessen them in clinical practice (Reitmanova, 2011).
Intersectionality	First coined by Dr. Kimberlé Crenshaw in 1989 to discuss the way in which specifically Black women's identities as both a woman and a Black individual intersect and compound to oppress them in the criminal justice system, it has since been adopted in many fields to address the multiple and compounding oppressions or privileges that individuals may experience due to their intersecting identities. Rather than striving for a competency or achieving certain knowledge, intersectionality encourages the HCP to reconsider power and privilege, whether it be their patient's or their own. In some instances, the teaching of CC or CS takes an intersectionality-based approach to ensure that SRSJ is upheld (see: Muntinga et al., 2015; Robinson et al., 2016).
Critical Consciousness	Critical Consciousness was developed out of post-Marxist theory as a way to liberate individuals from inequity through education– essentially teaching individuals to reflect on and resist the systemic inequities that plague society (Freire, 2002). This pedagogical approach lends itself well to SRSJ curriculum as it requires students to become aware of inequities and to learn how to combat them in an effort to work towards health equity. Additionally, Critical Consciousness "has the objective of addressing multi-systemic oppression at its core" (Jemal, 2017, p. 604), meaning that there is not solely a patient-focus to reaching health equity, but rather the SDOH can be accounted for. In a literature review completed in 2017, five key themes were attributed to critical consciousness training in health professions education (Halman et al., 2017). These characteristics included: "appreciating context"; "illuminating power structures", "moving beyond procedural"; "enacting reflection"; and "promoting equity and social justice" (p. 15).

Note. Included here are the definitions and uses of SA, Critical cultural approach, intersectionality, and critical consciousness.

Table 2

Concepts Relevant to SRSJ Curriculum

Concepts	Definitions/Implications
Cultural Competence (CC)	First utilized by the Social Work and Psychology fields, it quickly spread to other health fields. CC, often discussed in tandem with concepts of Cultural Humility and CS, differs slightly (Gallegos et al., 2008). As being competency-based, this approach to education and practice strives to educate health professions students and HCPs to recognize certain definable differences between cultures– and to be competent in their ability to do so (Greene-Moton & Minkler, 2020).
Cultural Safety (CS)	First coined by Ramsden and Māori nurses in the 1990s, and later reiterated by Ramsden (2002), CS is described as being subjective—allowing the "recipient of care to say whether or not the service is safe for them to approach and use" while the onus is put on the HCP to enact CS as well as to reflect on the power that they hold inherently by providing care to others (Ramsden, 2002, p. 6). CS has been defined as being based in power (Churchill et al., 2017; Curtis et al., 2019). While the premise of both CS and CC is to provide equitable care to individuals of diverse backgrounds, CS differs in that it recognizes not only differences, but the power dynamics that such differences create (Allan & Smylie, 2015; Churchill et al., 2017). In recognizing this power differential, CS also brings in the idea that systems-based change may play a role in creating culturally safe care, while CC may focus more so on individual actions towards creating safe care (Churchill et al., 2017; Curtis et al., 2019).
Global Health	At a baseline, Global Health is focused on addressing health disparities worldwide to work towards health equity. Instead of being particularly focused on a specific nation or population (such as Public Health), Global Health transcends "national boundaries and governments and call(s) for actions on the global forces that determine the health of people" (Kickbusch, 2006, p. 561). In this way, Global Health works towards health equity and has been cited as an early "champion" of working towards health equity in UME in the absence of SA mandates (Walling et al., 2021, p. 184). In an article by Beaglehole and Bonita (2010), a new definition of Global Health is proposed, providing a more tangible and actionable definition as: "collaborative trans-national research and action for promoting health for all" (p. 1).
Social Justice	"Social justice is defined as a just distribution of goods within society and examines the relationships between groups and individuals that influence the distribution of goods" (List, 2011, pp. 565-566). Within the health professions, Social Justice works directly with the SDOH, and addresses how inequity in health is a direct factor of systemic oppression and unequal distribution of goods– essentially social justice focuses on the root causes of health inequity and how these may be dismantled to provide equitable healthcare regardless of individuals' diverse identities (see: BCCDC Foundation for Public Health, Social Justice and Public Health section, n.d.; Canadian Nurses Association, 2006; Habibzadeh et al., 2021). Social Justice frameworks for education go a bit beyond the normal of simply educating, and instead seek to mobilize HCPs to act with "true generosity" in tackling health inequities– not simply paying them lip service (Freire, 2002, p. 45).
Health Advocacy	Hubinette et al. (2017) define health advocacy as composed of "activities related to ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change" (p. 128). Health Advocacy often deals with not solely patient-centred and population-centred interventions, but also policy-based interventions. Consequently, this approach goes one step further than simply learning about SDOH and cultural diversity, but also embodies the idea that change is possible and should be enacted by those in the healthcare field. This idea is also built upon in the 2015 CanMEDS competency of being a "health advocate" for UME graduates in Canada (Poulton & Rose, 2015). As stated by Poulton & Rose (2015), the CanMEDS role of Health Advocacy has transformed from a more "paternalistic" approach of advocating *for* individuals, to one in which physicians should be advocating *with* the individuals they serve (p. e58).
Social Determinants of Health (SDOH)	The SDOH, as defined by the WHO are "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" inclusive of "economic policies and systems, development agendas, social norms, social policies and political systems" (World Health Organization, n.d.). These determinants have a large impact on health outcomes and as such come under the purview of HCPs' practice. Various academic programs across the health professions strive to teach the SDOH alongside their biomedical curriculum (see for example: Denizard-Thompson et al., 2021; Thornton & Persaud, 2018). The SDOH is often implemented with a goal to have graduates confidently understand, identify, and ideally address the SDOH in practice.

Note. Listed here are the definitions and implications of concepts often focused on within the literature surrounding SRSJ, such as health advocacy, SDOH, CS, CC, global health, and social justice.

Regulatory Bodies

Although many health professions are self-regulated[7] through their respective colleges, such as nursing and medicine, there are a few that are not self-regulated, for example paramedicine[8]. While there is a mixture of professional regulation protocols, most health professions training programs are regulated at the provincial level and regulations differ by provinces and territories (see, for example: Ontario Health Regulators, n.d.; Saskatchewan, Saskatchewan Regulatory Bodies section, n.d.; BC Health Regulators, n.d.). Given that these professions represent a significant proportion of front-line health workers, the competencies and requirements for each are reviewed.

Medicine

In Canada, the profession of Medicine is regulated at both the federal and provincial level. At the federal level, the Medical Council of Canada ensures quality of physicians by administering a standardized qualifying exam (Medical Council of Canada, Route to Licensure section, n.d.). This federally regulated process is separate from the licensure process which is regulated at the provincial level for physicians. In Ontario, the licensing body is the College of Physicians and Surgeons of Ontario (Health Workforce Planning Branch, Licensing of Physicians section, n.d.). In addition to the professional regulation, there are also organizations

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[7] Self-regulation is "[t]he most common approach to the regulation of professions in Canada… Self-regulation is based on the concept of an occupational group entering into an agreement with government to formally regulate the activities of its members. As a condition of delegation of such regulatory powers, the governing or regulatory body is required to apply such powers in a manner that is guided by the public interest. Professional self-regulation is a regulatory model which enables government to have some control over the practice of a profession and the services provided by its members but without having to maintain the special in-depth expertise required to regulate a profession that would be required under direct regulation" (Human Resources Professionals Association, 2015).

[8] This is important to consider as self-regulation ensures that members of a certain profession are in fact professionals and are held to certain regulatory standards. In Ontario, the Ontario Paramedic Association has been lobbying for self-regulation since 2013, filing a request for self-regulation under the *Regulated Health Professions Act (1991)* (Ontario Paramedic Association, Paramedic Self-Regulation section, n.d.).

involved in the regulation of medical education. These regulating bodies vary depending on which period of education the medical student finds themselves in.

All medical education periods in Canada are regulated at the federal level. Undergraduate medical education (UME) in Canada is regulated by the Committee on Accreditation of Canadian Medical Schools of the Association of Faculties of Medicine of Canada, while postgraduate medical education (PGME) is regulated by separate bodies depending on medical specialization (The Association of Faculties of Medicine of Canada, Accreditation section, n.d.). The two bodies regulating PGME are the Royal College of Physicians and Surgeons of Canada for medical specialists, and the College of Family Physicians of Canada for family medicine PGME (Health Workforce Planning Branch, Licensing of Physicians section, n.d.). In this paper, focus is put on UME and the accreditation standards as outlined by the Committee on Accreditation of Canadian Medical Schools.

Nursing

For the nursing profession, licensing and regulation differ between the provinces and territories (National Nursing Assessment Service, RN, RPN and LPN Requirements in Canada section, n.d.). In Ontario, the nursing profession has been self-regulating since 1963, with the regulatory body being the College of Nurses of Ontario (CNO) (College of Nurses of Ontario, What is CNO? section, n.d.). Unlike professional regulation, in Ontario, entry-level[9] nursing education is not "regulated" but *approved* and may also be accredited (Almost, 2021). The CNO in Ontario approves these education programs while the Canadian Association of Schools of Nursing (CASN) handles accreditation (Almost, 2021). While approval is required for nursing graduates to be able to register following completion of their program, accreditation is voluntary

[9] Entry-level education is defined as that which ranges from a diploma to a master's degree (Almost, 2021). Therefore, both PN and BScN programs are approved by the CNO in Ontario.

(Almost, 2021). Approval by the CNO requires a lengthy review against standard criteria which looks at the program structure, curriculum and outcomes, and their ability to prepare students for professional competencies according to their class of registration (i.e. RN, RPN) (CNO, 2019, p. 3). Furthermore, to be approved, programs are to be routinely reviewed annually and *comprehensively* reviewed every 7 years (CNO, 2019).

Paramedicine

Paramedicine in Canada is regulated at the provincial level rather than through regulatory bodies such as professional colleges (see above footnote on self-regulation implications). In Ontario there are two regulating bodies: The Emergency Health Services Branch (EHSB) of the Ministry of Health and Long-Term Care (MOHLTC) and eight different Base Hospital Programs, which are associated with the MOHLTC (Ontario Paramedic Association, Self-Regulation FAQ section, n.d.). Despite the regulation of the profession at the provincial level, the training programs do not require accreditation through the Canadian Medical Association (CMA), other than the Advanced Care Paramedic programs (Ontario Paramedic Association, Self-Regulation FAQ section, n.d.). This poses a major issue for standardization of curriculum and consequently quality assurance of equitable care, and this is even acknowledged by the CMA (Ontario Paramedic Association, Self-Regulation FAQ section, n.d.).

Accreditation Standards

Accreditation serves as a way to guide programs to provide certain outcomes. For example, while nursing had been self-regulating for over 20 years prior, the move towards accreditation for baccalaureate nursing education in 1987 was another step towards providing quality assurance of the nursing workforce in Canada (Canadian Association of Schools of

Nursing, Accreditation section, n.d.). At this time, all Ontario BScN-granting educational units[10] go through the CASN accreditation process for their BScN programs (CASN, "Accredited BScN Programs" section, n.d.). However, as stated previously, accreditation is not mandatory (Almost, 2021; CASN, 2022; CASN, 2023). Additionally, in 2017, stakeholders relayed an interest in accrediting their practical nursing programs across Canada, resulting in the *CASN Accreditation Framework and Standards for Practical Nursing* (CASN, 2023).

In order to receive CASN accreditation, the educational units as well as the education program[11] for nursing programs need to provide evidence through a self-study report that indicates they are meeting each of the 6 standards listed by CASN for either baccalaureate or diploma granting nursing programs (see: CASN, 2022; CASN, 2023). Additionally, more information is collected by peer reviewers via virtual or in-person observation and interviews with members of the educational unit seeking accreditation (CASN, 2022). Within each standard are various key elements that are to be evidenced as being met by the self-report and/or the virtual or in-person peer-review assessment components of the accreditation process (CASN, 2022).

Canadian undergraduate medical education is accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS). However, this is a relatively recent change from the original accreditation arrangement of Canadian medical schools. Beginning in 1947, Canadian medical schools were accredited by the U.S.-based Liaison Committee on

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[10] "The educational unit refers to the faculty, school, or department of a post-secondary institution delivering a baccalaureate program of nursing, either solely or in collaboration with other educational units in other academic institutions. The educational unit includes the leadership, organizational and administrative structures, policies, processes, faculty, resources, and environment of the education program under review" (CASN, 2022, p. 6).

[11] The "education program" is separate from the "educational unit", for example, "the unit of an accreditation review and subsequent accreditation status is of a given education program, delivered by a given educational unit. Schools offering practical nursing programs may offer more than one practical nursing education program including, for example, a basic diploma program and others for graduates of an international diploma program… As they may vary in quality, each education program is reviewed against the education program standards" (CASN, 2023, p. 8).

Medical Education (LCME), before the creation of CACMS in 1979 which resulted in a complicated dual-accreditation process for the subsequent 35 years (CACMS, 2023). Beginning in 2021, CACMS assumed full accrediting authority of Canadian medical schools without necessitating review from the LCME, unless otherwise agreed upon and deemed necessary (CACMS, 2023).

While accreditation is often about quality assurance overall, it can also serve to promote particular outcomes such as future practice among students and graduates. One of these key outcomes as evidenced by the accreditation standards for medical faculties in Canada is SA. Since the formal incorporation of SA into the accreditation standards for Canadian medical schools in 2015, many schools have implemented varying initiatives to address this vital area of work such as community-based learning, stakeholder discussions and workshops involving individuals from the community to inform the direction for medical education (see: Walling et al., 2021). Refer to Table 1 for more information.

A shift has also been seen among nursing accreditation standards, from previous years (2014) to the current standards (2022). In the previous standards, the only explicit mention of SRSJ-related curriculum was that accredited baccalaureate nursing programs provide "opportunities for students to develop theoretical and practical knowledge of relational practice, cultural safety, and social and political advocacy" (CASN, 2014, p. 26). Beginning in 2020, a whole new section devoted to accountability can be seen in addition to this requirement. CASN states that the program must fulfill "its societal role… [developing] accountability in baccalaureate students who possess the knowledge, skills, and attitudes needed to enter the nursing workforce, provide safe and ethical care, and advance in the profession as lifelong learners" (CASN, 2020, p. 20). In addition to these elements, a specific clause has been added to

this update of the standards with respect to standard 4 "Program Framework & Curriculum" which states that curriculum is to address "Action 24 of the Truth and Reconciliation Commission programs of nursing to integrate the United Nations Declaration on the Rights of Indigenous peoples, human rights, the history of Indigenous peoples in Canada, Indigenous teachings and practice, intercultural competency, and anti-racism" (CASN, 2020, p. 19). Of particular importance is the inclusion of anti-racism alongside intercultural competency. Whereas CC can be competency-based, and therefore a learning outcome that students strive to master (refer to Table 1), anti-racism[12] is an active process that learners must continue to use to challenge their biases and those of others to promote safer care. Additionally, an interesting point of consideration is the use of the term "accountability" within this version of the accreditation standards. Nursing appears to be aligning with a more socially accountable framework wherein programs and their educational units are to be focusing on things such as "equity, inclusion and respect of diversity… [being] reflected in the stated values, policies, and relationships of the educational unit" (CASN, 2020, p. 14). However, whereas UME SA standards implicate all levels of the institution in serving the community (refer to Table 1), similar verbiage is yet to be seen in the CASN accreditation standards. It is also important to note that the specific values listed within the CASN accreditation standards of equity, inclusion and respect of diversity are very explicit and not solely focused on a general idea of community-driven education and efforts (such as the mission of SA). A focus on anti-racism and the need to address the TRCC calls to

[12] As the CASN's *National Nursing Education Framework* (2022) states, "for someone to be anti-racist, they must challenge the structural racism and other oppressive systems that intersect by shifting power 'so that marginalised and minoritised peoples can live healthily and thrive' (Crear-Perry et al., 2020, p. 451.). Nurses must understand the root structural causes of racism within broader social trends and depart from individualistic explanations of racism (Blanchet Garneau et al., 2018)."

action extend beyond the SA framework of meeting community needs, and instead highlights specific educational requirements that may help assist the mission of SA or SRSJ more broadly.

There have been significant changes to the accreditation standards, yet while there appears to be more direction of what is to be covered in the curriculum in terms of SRSJ and what competencies are to arise, there continues to be a lack of definition for social and political advocacy in the nursing profession. While social and political advocacy may seem straightforward, the way in which it should be taught and the implications of this work in the nursing profession are unclear from this guiding document. Conversely, there are definitions for a handful of the key terms mentioned following the listed expectations of graduates. However, there once again appears to be a lack of direction of how these concepts should be instilled within graduates and how educators should be teaching such concepts. The only exception is that of anti-racism, for which the framework suggests that "curriculums should discuss, for example, the difference among anti-Black racism, anti-Indigenous racism, anti-Asian racism, and racism against other racialized peoples" with students' practice reflecting "the articles of the *United Nation's Declaration of the Rights of Indigenous Peoples* (2007) and the documents related to the *OHCHR and the International Decade for People of African Descent 2015-2014,* as proclaimed by the United Nations Human Rights Office of the High Commissioner (2022)" (CASN, 2022, p. 22).

Paramedicine, unlike medicine and nursing, does not have accreditation standards but competencies that are listed by the Paramedic Association of Canada (PAC). These competencies are discussed in the following section alongside the competencies outlined by regulatory bodies of nursing and medicine.

Competencies

An approach that focuses on competency-based education framework seems to be ingrained in today's healthcare system (Morcke et al., 2013). Because of this, competencies are often seen within the accreditation standards as a way to measure students' preparedness to work in their new profession. Many regulatory bodies and colleges for HCPs and accrediting bodies for health profession training programs have also turned to instating CC as a goal for their graduates and professionals (see: Greene-Moton & Minkler, 2020).

Medicine

In 1996, the Royal College of Physicians and Surgeons of Canada (RCPSC) approved the first CanMEDS framework—the competency framework used for education of physicians in Canada (RCPSC, n.d.a.). From the 1996 framework to the 2015 framework, the document has been updated with verbiage and roles reflective of the evolving healthcare landscape and physicians' needs to meet the demands of the healthcare system (Frank, 2004). The seven recognized roles of a physician in Canada are *Professional, Communicator, Leader, Health Advocate, Scholar,* and *Collaborator*—these combine to form the central role of the physician as a *Medical Expert* (Frank, 2015).

The RCPSC defines the *Health Advocate* role as physicians contributing "their expertise and influence as they work with communities or patient populations to improve health… work[ing] with those they serve to determine and understand needs, speak[ing] on behalf of others when required, and support[ing] the mobilization of resources to effect change (Frank, 2015. P. 11). Additionally, this means "respond[ing] to an individual patient's health needs by advocating with the patient within and beyond the clinical environment" (RCPSC, n.d.b.). To enact this role, it is expected that physicians "work with patients to address determinants of

health that affect them and their access to needed health services or resources… work with a community or population to identify the determinants of health that affect them… [and] work with patients and their families to increase opportunities to adopt healthy behaviours" (RCPSC, n.d.b.).

The CanMEDS *Scholar* role relays that physicians should "demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship" (Frank, 2015, p. 13). To meet this goal of learning and educating, physicians should "identify opportunities for learning and improvement by regularly reflecting on and assessing their performance using various internal and external data sources… recognize the influence of role-modelling and the impact of the formal, informal, and hidden curriculum on learners… promote a safe learning environment… [and] ensure patient safety is maintained when learners are involved" (RCPSC, n.d.b.). This is an important role because it not only implicates the future professional but the future of the profession—showing the connection between current physicians and future physicians by way of role-modelling.

As a *Professional*, the RCPSC expects that physicians "are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulations, and maintenance of personal health" (Frank, 2015, p. 15). Competencies within this area include: a demonstration of "honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality… accountability to patients, society, and the profession by responding to societal expectations of physicians… [and] a commitment to patient safety and quality improvement" (RCPSC, n.d.b.). Of note here is the need for accountability to patients and society as well as the importance of respecting diversity.

Lastly, the role of *Communicator* relays that physicians form a therapeutic relationship with those they serve “for effective health care” (Frank, 2015, p. 5). To do this, it is expected that physicians be able to “communicate using a patient-centred approach… characterized by empathy, respect, and compassion… recognize when the values, biases, or perspectives of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly… [and] facilitate discussions with patients and their families… that [are]… respectful, non-judgmental, and culturally safe (RCPSC, n.d.b.). While all of these roles and competencies are implicated in one way or another within the concepts of SRSJ, it should be noted that the only explicit mentions of concepts related to SRSJ is that of the *Health Advocate* role and the single mention of the importance of a culturally safe communication style.

Nursing

Since CASN’s changes to their accreditation standards in 2020 to include accountability among nursing graduates so that they are able to provide ethical and culturally safe care, there are key expected outcomes of this change. These outcomes are such that learners are instilled with “the ability to reflect on one’s practice, take responsibility for one’s actions, and continuously improve”; “the ability to anticipate, recognize, and manage situations that place a person or a community at risk”; and are taught to “engage in relational practice and advocacy and provid[ing] culturally safe care” (CASN, 2022, p. 20). Such key elements are descriptive and describe a more holistic expectation of what baccalaureate nursing graduates should embody upon completion of their programs. Inherent within these elements is the idea of reflexivity and recognition of the importance of CS. Furthermore, the 2022 *National Nursing Education Framework* highlighted the need for curricular focus on such SRSJ-related topics of anti-racism,

advocacy, social justice and truth and reconciliation. This document relays that baccalaureate nursing students should be able to: "examine critically the effects of racism and the monocultural roots of health care services in Canada on health care inequities"; "analyze the intersection of social, structural and/or ecological determinants of health on the health of individuals, families… communities and populations" (p. 10); "demonstrate cultural humility, cultural safety, anti-racist, and anti-discriminatory nursing practice" (p. 14-15); "enact care that reflects Indigenous perspectives and values in health and healing practices" (p. 15); "identify one's own beliefs, values, implicit bias, and assumptions and their potential effect in communication with diverse clients and health care team members… [and] communicate respectfully, assertively, and in a culturally safe manner with diverse clients and health care team members" (p. 17); and "advocate for change to address racism, social injustices, and health inequities in nursing care or nursing services" (p. 21).

For the college-level nursing programs, the province of Ontario does have program standards for programs offered through public colleges. For practical nursing (2-year nursing program) the vocational learning outcomes relevant to this study are the ability to: "communicate therapeutically with clients* and members of the health care team*", "plan safe and competent nursing care, based upon a thorough analysis of available data and evidence-informed practice* guidelines", "act equitably and justly with clients* and members of the health care team*" and "practise in a self-regulated*, professional and ethical manner, complying with relevant legislation and with the standards of both the regulatory body and the practice setting to provide safe and competent client* care" (Ontario, 2012, p. 6).

When listing how these may look in practice, a variety of examples are given. For "communicate therapeutically with clients* and members of the health care team", the document

lists interact with the client*, incorporating professional intimacy*, and appropriate use of the power inherent in the care provider's role" (Ontario, 2012, p. 7). This demonstrates a recognition of power dynamics and their role in influencing safe patient care (relating to CS). For "plan[ing] safe and competent nursing care", they list "consider the client's* acuity*, personal and cultural needs, expected outcomes and the availability of resources to establish priorities when providing care" and "incorporate the determinants of health* in all aspects of care" (Ontario, 2012, p. 9). Within the standard of "act[ing] equitably and justly with clients*", there are many relevant suggestions. However, a point of consideration is the use of the term "culturally appropriate care" (Ontario, 2012, p. 12). While examples of this competency focus on patient-centred care, the use of this term may undermine the value of need for emphasis on culturally *safe* care. Lastly, the competency of "practis[ing] in a self-regulated*, professional and ethical manner… to provide safe and competent client* care" has listed examples such as "accept[ing] accountability* for own decisions and actions" and "recogniz[ing] the effect that personal belief systems, cultural/ethical values, and assumptions have on nursing practice*" (Ontario, 2012, p. 15).

It is evident throughout these standards, that while practical nursing education does not require accreditation through CASN, there is much guidance for these programs. While the accreditation standards and *National Nursing Education Framework* (2022) through CASN appeared to lack information regarding how to specifically teach CS, social justice, advocacy, SDOH, and other concepts relevant to SRSJ, the Ontario program standards for practical nursing seem to be teeming with vital suggestions for educating just and socially responsible providers.

Paramedicine

Similarly, given the lack of accreditation requirements, paramedicine has competencies, as outlined by the PAC. The competencies are general and include objectives such as "acknowledge cultural differences" (p. 25), "value patient advocacy" (p. 28), "identify cultural factors that may affect non-verbal communication" (p. 39), and "identify cultural differences that affect the demonstration of respect" (42) (Paramedic Association of Canada, 2011). Such general guidelines are also not specific to paramedicine– but rather characteristic of emergency medical responders (EMR) in general.

In addition to these professional competencies, the Government of Ontario has listed program standards for Paramedic programs administered through Ontario public colleges (see: Ontario, 2008). Within these standards, there are vocational learning outcomes. Those listed for the paramedicine programs that may be relevant to the study at hand are: "1. communicate and interact effectively and appropriately with patients* and others", "2. assess patients* using relevant theory and practices and in compliance with current legislation*, regulations*, standards, and best practice* guidelines*", and lastly, "11. integrate and meet legal, ethical, and professional* responsibilities while providing optimal care* for patients*" (Ontario, 2008). For the first learning outcome, the document lists a number of practical applications such as: "utilize a non-judgmental, empathetic, respectful, honest, and genuine approach to communications", "adapt communication techniques based on factors influencing patient and family communication; for example, age, capacity, comprehension level, and ethno-cultural practices", "respect and value patients from diverse backgrounds", and "advocate for patient's rights*" (Ontario, 2008). For the second learning outcome, the document suggests this may look like "integrat[ing] critical thinking, decision-making skills, and best practice guidelines into patient's

assessment*" (Ontario, 2008). Lastly, for learning competency 11, the document lists things such as "be accountable for one's own actions and adopt due diligence" and "engage in reflective practice to promote ongoing competence*" (Ontario, 2008). In addition to the standards, all Ontario college programs are to include a general education component. The requirement is in place so "that graduates have been engaged in learning that exposes them to at least one discipline outside their main field of study, and increases their awareness of the society and culture in which they live and work" (Ontario, 2008). While there are no set requirements of what this has to look like, there are a number of themes that are listed as possible contending content for college programs. These include: "arts in society", "civic life", "social and cultural understanding", "personal understanding" and "science and technology" (Ontario, 2008). While each has their own description, they are not exhaustive nor comprehensive. This provides colleges with flexibility in choosing what combination of content to provide their students in order to meet the general education requirement.

Despite the lack of regulating bodies specific to paramedic education, clearly there is guidance of how such education should be undertaken in Ontario. However, while certain concepts are mentioned as integral to this education, there is a lack of clarity with regards to how this should look for the profession. For example, there are no specific mentions of what advocacy should look like, nor is there mention of cultural safety or other related concepts. It has been recognized by both the Ontario Paramedic Association (see: Ontario Paramedic Association, Paramedic Self-Regulation section, n.d.) and PAC that the profession is changing due to societal pressures to perform more work outside of the extra-hospital setting. This means that more diagnostic work is being done, as well as work in "non-traditional" settings such as "hospitals, community services, military and industry" (Paramedic Association of Canada,

2011). With the expanding professional scope of paramedicine in Canada, it is important that the same knowledge on SRSJ that is provided to those who most commonly work in the more "traditional" healthcare settings is also provided to paramedics.

Literature Review

The guiding question for the literature review was "what are the current practices within health professions education aligned with disseminating just and socially responsible concepts to students across regions with a history of colonization (specifically Australia, the U.S., Canada, South Africa, New Zealand, and the U.K.)?" Refer to Appendix A for full methodology. Resulting themes emerged, namely: medical education and nursing programs are the main recognized proponents of SRSJ-aligned curriculum (see, for example: Abbott et al., 2020; Allen et al., 2013; Biswas et al., 2020; Crampton et al., 2016; Denizard-Thompson et al., 2021; Dogra et al., 2009; Edwards et al., 2015; Essa-Hadad et al., 2015; Hayman et al., 2020; Patel et al., 2021; Ratcliffe et al., 2018; Scheffer et al., 2019; Schmidt et al., 2017; Thornton & Persaud, 2018; van den Heuvel et al., 2014; Walsh et al., 2020; Wilson et al., 2020); there is a variety of pedagogical approaches to teaching SRSJ-related concepts (i.e. experiential, service-learning, online modules, mentorship, yarning); and a need for further research is recognized–mainly looking for continued or longitudinal follow up with students who have been exposed to such curriculum (see: Biswas et al., 2020; Mpofu et al., 2014; Schmidt et al., 2017). Additionally, important considerations were brought to light through the review process, such as the barriers that are frequently noted when implementing such coursework related to SRSJ, including limited time within academic programs (Forsyth et al., 2019a; Glauser, 2018); logistics of knowledge dissemination from research to academic courses (Glauser, 2018); organizational barriers to replacing and updating current program requirements and courses (Glauser, 2018); and lack of

qualified persons to teach such curriculum (Forsyth et al., 2019a, 2019b; Shah & Reeves, 2015). Other themes that arose across studies included the implications of hidden curriculum and role modeling; importance of emotional connections to the curricular content; earlier versus later implementation of SRSJ-aligned curriculum; humanizing versus "othering" curriculum; implications of interprofessional collaboration on SRSJ; and the importance of active and critical reflection in learning SRSJ-aligned curriculum. All of these will be touched upon in the subsequent subsections. The following sections are organized into categories: Current Practices for Instilling SRSJ, Current Gaps, and Frameworks and Suggestions for Teaching SRSJ. Within the discussion of the second category, frameworks used are detailed and this theme concludes with suggestions from the literature for implementing SA in health professions programs (which can be extended to implementing SRSJ). Some of the sections have multiple themes that overlap and are interrelated in terms of what is required or should be considered when implementing SRSJ. For example, the section entitled "Role Models, Basic Knowledge & Hidden Curriculum" includes the ideas that in order to address hidden curriculum, basic knowledge regarding SRSJ and role models who are aware of and who work towards SRSJ need to be present in educational settings. The findings discussed here form the backbone of what is discussed following analysis of the data (as discussed in the "Thematic Analysis & Pattern Matching" section).

Current Practices for Instilling SRSJ

Indigenous Curriculum versus "General" Curriculum

Within the literature on SRSJ concepts in health professions education a dichotomous phenomenon is demonstrated wherein SRSJ-aligned coursework, notably in Canada and Australia, is split into either more generalized concepts (for example, see: Hayman et al., 2020; van den Heuvel et al., 2014; Veras et al., 2013) or Indigenous-specific curriculum (see: Allen et

al., 2013; Beavis et al., 2015; Dickson & Manalo, 2014; Forsyth et al., 2019a, 2019b; Shah & Reeves, 2015). Because of the differences in curricular foci, the barriers that particular programs encounter also vary. For instance, one of the main findings with regards to implementing Indigenous-focused SDOH curriculum is the need to utilize knowledge keepers to instruct on these topics (Beavis et al., 2015; Forsyth et al., 2019a, 2019b; Shah & Reeves, 2015), whereas the more general SDOH or Global Health-focused curriculum tends to cite more systemic barriers such as lack of time and institutional policies (Glauser, 2018). In light of this, when looking at Indigenous-specific SDOH curriculum, the literature advocates for including Indigenous knowledge keepers to shed light on these topics, along with working in tandem with community organizations, broaching the next topic: *glocalization* (Kickbusch, 1999).

Glocalization & Place-Based Learning

Across the studies reviewed, there is a call to incorporate community organizations in the generation and implementation of SRSJ-aligned curriculum–whether for Indigenous-specific SDOH and CS practices (Beavis et al., 2015; Forsyth et al., 2019a, 2019b; Richardson & Murphy, 2018) or for more broad SDOH and CS knowledge, in an attempt to contextualize learned knowledge for students (Biswas et al., 2020; Denizard-Thompson et al., 2021; Goez et al., 2020; Patel et al., 2021). Raphael & Sayani (2017) cite Kickbusch's (1999) term "glocalization," referring to the need to take concepts such as Global Health and put a local, contextualized perspective on knowledge and practices. Other curriculum models employ this same idea of contextualized learning by incorporating different knowledge keepers specific to a local region such as religious leaders (Essa-Hadad et al., 2015), and as mentioned earlier, Indigenous knowledge keepers such as Elders and Indigenous scholars (Beavis et al., 2015; Richardson & Murphy, 2018; Shah & Reeves, 2015). These suggestions are also echoed in other

studies where SRSJ are fostered or wherein curriculum is sought to be more focused on community needs (a tenet of SA) (see: Abdalla, 2014; Belita et al., 2020; Fung & Ying, 2021; Rourke, 2018). All of these practices are supported by the *Global consensus* (2010), where the idea of "balancing global principles with context specificity" is named a key direction for fostering SA[13] in medical education (pp. 10-11).

In addition to incorporating knowledge keepers and key stakeholders as curriculum experts and program consultants, there are also studies and papers indicating that place-based learning contextualizes SRSJ-aligned curriculum (Behforouz et al., 2014; Hatcher et al., 2014; Murray et al., 2012; Ross, 2014). However, the way in which place-based learning is facilitated varies by program and curricular focus, and results in varied outcomes. For example, in a study done with Physiotherapy and Occupational Therapy students, international placements were seen (Veras et al., 2013), whereas in other programs local placements were favored (Biswas et al., 2020; Essa-Hadad et al., 2015; Snyman & Geldenhuys, 2019; Harrison et al., 2020). In the Veras et al., (2013) study, the results of a survey of rehabilitation students from 5 different Canadian universities indicated that the concepts of GH were learned through study abroad components; however key concepts related to health equity in GH were not considered to be important. For example, students indicated that it is necessary to "understand the relationship between health and human rights" as fundamental to their learning, but not the "relationship between access to clean water, sanitation, and nutrition on individual and population health" (Veras et al., 2013, p. 4). Students also tend to focus on the experiences as contextualized in *other* countries, indicating more interest in learning "healthcare services in less developed and developing countries" and "understanding the different structures of health care around the world" rather than focusing on

[13] While the *Global consensus* (2010) document is specific to SA, SA is one avenue for implementing SRSJ within health professions education.

these issues locally or applying such Global Health concepts to their local context (pp. 4-5). Such findings are important to discuss as they point to the fact that there is a discrepancy between the results of SRSJ-aligned curricular models that have an international outlook (i.e .study abroad or international placements), and locally-based models (i.e. service learning and experiential learning in local community-based settings).

In the work by Ross et al. (2014), the idea of place-directed learning comes into play. The authors discuss the implications of incorporating "place" into the development of a health professions curricular model. It is mentioned that little attention and effort has been paid towards ensuring place is incorporated into UME as since the publication of the Flexner report (1910), the move to train medical students in teaching hospitals in urban centres was established (Ross et al., 2014, p. 1251). However, dismantling this status quo and putting place back into health professions education helps to promote recruitment and retention of competent HCPs who are knowledgeable of the context in which they work and who are able to provide just and socially responsible care (in this case, in Northern Ontario) (Ross et al., 2014). Additionally, as mentioned by Schiff & Møller (2021), "[w]hether medical professionals are educated within your community and through curriculum that is geared to the particular circumstances of the people living there also has an impact on the quality of health care available" (p. 9). As can be seen, there is no "one size fits all" curriculum for learning to be a just and socially responsible HCP as there are different ideas of where SRSJ start– whether global in nature, or local. Instead, what is seen is a mix of foci in either local community health, Global Health, or a combination of both– focusing on Global Health but applying to local context (i.e. glocalization).

Other literature points to the fact that international clinical placements for health professions students may also do more harm than good without proper considerations of program

underpinnings (Mill et al., 2010; Racine & Perron, 2011). Most notably, such placements can reinforce the practice of "othering" wherein peoples in other countries are exoticized and the experiences are disjointed, not connecting the global with the local (Mill et al., 2010). Such programs also have the capacity to perpetuate neocolonialism as they may be voyeuristic in nature– once again reflecting the "othering" practices that are reinforced through programs that do not take a critical stance to their pedagogy (Racine & Perron, 2011). It should be noted however that such tendencies may be avoided through the positioning of the program using an intersectional or critical postcolonial framework which recognizes the need to check power differentials and implement critical consciousness throughout the learning process (Racine & Perron, 2011; Van Herk et al., 2011). However, such critical philosophical underpinnings should also be applied to locally-based programming that works with marginalized populations and populations made vulnerable. Given these findings it may be surmised that while international placements and internationally-focused programming may result in improved understanding of SDOH and CS, locally-focused programming may also contribute to acquisition of such knowledge, as well as promote SRSJ of HCPs for local communities.

Thus, while the literature tends to focus on either implementing Indigenous health or other particular content or not, a focus on critical reflection and critical consciousness may help to better inform future HCPs, as discussed in the following sections.

Emotion-Evoking Curriculum & Critical Reflection

Across the literature there are various instances in which emotional connections are mentioned as important to acquisition of SA-aligned knowledge (Abbott et al., 2020; Allen et al., 2013; Beavis et al., 2015; Uy & Dimaano, 2020; van den Heuvel et al., 2014; Walsh et al., 2020). For instance, Beavis et al. (2015) who looked specifically at Indigenous-focused health equity

curriculum and what should be included in Canadian health professions training programs (as per Indigenous stakeholders and knowledge keepers who were interviewed), cited the need for emotional connection. In this specific context, the participants in the study note that to make an emotional connection is to cement the knowledge (in this case colonial history and implications on Indigenous health), into the learner's memory (Beavis et al., 2015, p. 6). Other implications of emotional connections to such curriculum include stimulating difficult discussions, challenging racial biases (Allen et al., 2013) and developing empathy for people disadvantaged by SDOH (van den Heuvel et al., 2014; Walsh et al, 2020). Oftentimes the emotion-evoking component of such curriculum is cited as paired with components of reflection (see: Allen et al., 2013; Mezirow, 1991; Uy & Dimaano, 2020; van den Heuvel et al., 2014; Walsh et al., 2020).

Reflection throughout the studies varied, from critical reflection based on mandatory essays or written pieces (Crampton et al., 2016, Denizard-Thompson et al., 2021; Essa-Hadad et al., 2015; Harrison et al., 2020; Kickett et al., 2014; Schmidt et al., 2017; Snyman & Geldenhuys, 2019; Uy & Dimaano, 2020; van den Heuvel et al., 2014), to even case reports and simply reflection through field notes (Biswas et al., 2020). However, many studies discussing curricular models that included reflection reported positive outcomes in terms of students' acquisition of knowledge specific to SRSJ-aligned curriculum, regardless of reflective tool used (Biswas et al., 2020; Denizard-Thompson et al., 2021; Essa-Hadad et al., 2015; Harrison et al., 2020; Schmidt et al., 2017; Snyman & Geldenhuys, 2019). Such results indicate that reflection, especially that which is critical in nature, allows individuals a higher level of understanding of the complex concepts underpinning SRSJ such as SDOH, personal biases, and CS (Ng et al., 2020). Critical reflection is not innate, but learnable (Ng et al., 2020), and is essential to what

Mezirow (1991) calls "transformative learning" as it challenges the very ideas upon which current knowledge and biases are based (p. 18).

Interprofessional Education

Another common programmatic consideration was the inclusion of material on interprofessional education (IPE). More specifically, some programs incorporate an interprofessional aspect to their curriculum-- forcing health professions students of different disciplines to work collaboratively on learning SRSJ-related concepts (Kaufman et al., 1979; Snyman & Geldenhuys, 2019). Such initiatives not only contribute to just and socially responsible HCPs who know how to work collaboratively to mitigate health inequities, rather studies indicate that such training helps prepare HCPs to work in more complex settings, including rural healthcare settings (Mpofu et al., 2014; Snyman & Geldenhuys, 2019). Such findings indicate that there is more to SRSJ than simply teaching health professions students to be self-aware, reflexive, and able to recognize and act on SDOH in practice– it also requires that they work together towards health equity.

Humanizing versus "Othering" Curriculum

In light of health disparities faced by peoples of marginalized and minority backgrounds, health professions SRSJ-aligned curriculum attempts to contextualize the situation and teach students to recognize differences. This contributes to the construction of an "other" in many courses teaching on SDOH and CS. For instance, such othering effects can be seen when curriculum focuses on specific ethnic or cultural groups (Beavis et al., 2015; Forsyth et al., 2019b; Paul et al., 2018). A literature review conducted in 2009 indicated that in the United Kingdom, United States, and Canada "there has been [a] tendency to emphasize teaching about different or 'other' cultures rather than developing awareness of one's own biases and

prejudices" (Dogra et al., 2009). Such construction of the "other" was shown to result in altered care for patients who were identified as "other" (Kirkham, 2003, p. 769). However, while this may result in problematic mindsets, where health professions students seek to gain competence in knowledge of another culture, active reflection on the creation of an "other" can result in a HCP gaining better insight into how they are also an "other", reinforcing the idea that such differences are social constructs and should not affect care (Paul et al., 2018). As Banks (2014) says: "[i]ndividuals who know the world only from their own cultural perspectives are denied important parts of the human experience and are culturally and ethnically encapsulated…[However, they] can get a full view of [their] own backgrounds and behaviors…by viewing them from the perspectives of other cultures." (p. 2). Thus "othering" curriculum, while not ideal, when paired with critical reflection and pedagogy, may actually contribute to more just and socially responsible HCPs.

Role Models & Hidden Curriculum

One helpful tool for learning how to include SDOH considerations in clinical practice and to provide just and socially responsible care, mentioned by some, is seeing others do so (Naz et al., 2016; Patel et al., 2021; van den Heuvel et al., 2014; Walsh et al., 2020). Patel and colleagues (2021) provided an example of role modelling, in which a "cascading mentorship" model is incorporated into UME and medical residency in order to teach future physicians how to provide socially responsible care, acting on the SDOH in clinical practice while employing CS. In this article, such cascading mentorship was facilitated with UME students acting as peer mentors to youth in at-risk environments, and resident physicians serving as mentors to those same UME students (Patel et al., 2021). However, role modeling is noted throughout various papers and studies as being beneficial for acquisition of knowledge and skills in general (Cruess

et al., 2008; Kumagai & Lypson, 2009; Snyman & Geldenhuys, 2019; Sternszuz & Cruess, 2016; Mezirow, 1991). As such, the idea of mentorship and role modeling for health professions students– mostly medical students, has also been cited by several studies as a necessary component for learning SRSJ (Abbott et al., 2020; Kaufman et al., 1979; Naz et al., 2016; Patel et al., 2021; Ross, 2018; van den Heuvel et al., 2014; Veras et al., 2013; Vikstrøm et al., 2017). These studies point to the necessity of having well-trained mentors in both academic and clinical settings who embody the concepts that they are disseminating to their students. In addition to studies evaluating current education initiatives, one study looking at current HCPs indicated that having role models during academic learning contributed to HCPs embodying advocacy in practice (Law et al., 2016) and accreditation standards and competency frameworks, echo the need for such role modeling to be present in future HCPs (See: Frank et al., 2015; CASWE, 2021). As such role-modeling is a must in both the practical and the academic setting.

The second concept touched on in this section also extends outside of the four walls of the traditional classroom: hidden curriculum. First coined by educational psychologist Philip Jackson, this idea has been brought into the medical education realm and posed in a number of studies as an implication of working in clinical settings (Beavis et al., 2015; Forsyth et al., 2019a; Paul et al., 2018; Ratcliffe et al., 2018). Essentially, hidden curriculum is a "set of influences that function at the level of organizational structure and culture" (Hafferty, 1998, p. 404). Included in the hidden curriculum are educators and role models (i.e. clinical preceptors and HCPs working with students), as well as common staff practices and policy implications within the clinical setting (Kirkham, 2003; Paul et al., 2018). Hidden curriculum can have reverse effects on the process of learning SRSJ, especially in the way of role models exhibiting behaviours and practices that contradict students' learned knowledge (see for example: Hopkins

et al., 2018). Yet looking at hidden curriculum as purely negative is cautioned against as it may be a useful tool in learning "what it takes" to be a good HCP for those negatively impacted by it (Paul et al., 2018, p. 6). While the hidden curriculum is widely recognized, there is also a call to not only align SRSJ priorities at the clinical level (to address the hidden curriculum) but also at the level of the academic program that such just and socially responsible health professions students are coming from (Paul et al., 2018). Essentially there should be an "alignment of priorities", meaning that all facets of the healthcare agenda should be vetted to ensure that every environment, lesson, practitioner and educator is working towards SRSJ (Paul et al., 2018).

Including Diversity in the Classroom

While many SRSJ initiatives across schools and programs include a goal of being more representative of the local community in student admissions, there are few studies that discuss the advantages that such diversity in practice lends to the health professions classroom. In one study conducted in Australia, the inclusion of a diverse student cohort led to enriched discussion and learning surrounding SDOH and CS (Dickson & Manalo, 2014). Instead of simply talking about, in this case, Indigenous populations and cultures and "celebrating" them as Ajodhia-Andrews (2013) argues against, the inclusion of Indigenous students in the conversation led to insight and perspectives often underrepresented or unheard (Dickson & Manalo, 2014). However, this program was short, and not longitudinal in nature– something that scholars in education call an "additive" approach to multicultural education (Banks, 2014). What this means is that rather than integrating the SRSJ-aligned content into pre-existing curriculum and teaching it over the course of an academic term or an entire program, content is added through short modules that may be connected to pre-existing content, but are often seen as extra or supplemental. This is especially important as in the Dickson & Manalo (2014) study, the

program model utilized was the merging of two separate programs into one (one program focused on GH, and the other focused on Indigenous health). Thus, the benefits of including diversity of perspectives in both of these courses was only reaped for the few months that the programs were able to collaborate during the academic term. This will be touched upon in the next section.

Curriculum Timeframe & Duration

SRSJ curriculum differed in lengths varying from as short as 3 hours for UME (Hayman et al., 2020), nursing, physician assistant, and many other health professions programs (Shah & Reeves, 2015) to over the course of 4 years of the health professions training (in this case specifically dental education) (Forsyth et al., 2019a). Length of curriculum duration appears to be independent of overall program length as some programs that are typically four years in length (i.e. UME and nursing) are implementing both shorter and longer duration SRSJ-aligned curriculum initiatives. Despite the range in program lengths, it was mentioned in several studies that longer implementation was favored (Benrimoh et al., 2016; Crampton et al., 2016; Denizard-Thompson, 2021; Doobay-Persaud et al., 2019; Goez et al., 2020; Hayman et al., 2020; Mangold et al., 2019; Mill et al., 2010; Ryder et al., 2019). Key stakeholders, focusing on Indigenous SDOH curriculum, indicated that longitudinal exposure to Indigenous health concepts was necessary given the historical and postcolonial implications on Indigenous health, meaning that context needed to be provided before Indigenous-specific SDOH and CS could be broached (Beavis et al., 2015). In addition to the duration of SRSJ-aligned curricular programs, the point in time in which they were offered differed. Some studies advocated for earlier exposure to CS and SDOH concepts (Beavis et al., 2015; Biswas et al., 2020; Essa-Hadad et al., 2015; Kickett et al., 2014; Mill et al., 2010; Snyman & Geldenhuys, 2019), while other programs included SRSJ-

aligned curriculum later on– coinciding with clinical exposure (Abbott et al., 2020; Denizard-Thompson et al., 2021; Kaufman et al., 1979). Overall, it is recommended that SRSJ-aligned curriculum such as multicultural education, Indigenous-focused SDOH curriculum, and curriculum on CS be taught earlier on in health professions programs and longitudinally over the course of such programs (Beavis et al., 2015; Dogra et al., 2009; Forsyth et al., 2019).

Shifting Curricular Focus to Advocacy

In addition to the need to shift how SRSJ curriculum (for example, SDOH or Global Health) is taught and conceptualized, much literature points to another gap in current approaches to teaching these concepts: the need to address advocacy in health professions training, especially in UME (Benrimoh et al., 2016; Boroumand et al., 2020; Frank et al., 2015; Global Consensus for Social Accountability of Medical Schools, 2010). In a perspective piece by Sharma et al. (2018), UME approaches to teaching on SDOH are defined as "content-rich, action-poor" and perpetuating health inequities by painting SDOH as something inherent to different populations, rather than something to be addressed, again falling into the trap of the biomedically-oriented healthcare system of education wherein Cultural *Competence* is the goal rather than critical thinking and Cultural Safety (p. 26). While many programs attempt to teach health professions students to be patient advocates (see: Biswas et al., 2020; Essa-Hadad et al., 2015; Haughton et al., 2013; Patel et al., 2021; Murray et al., 2012; Shah & Reeves, 2015; Thompson et al., 2011; Walsh et al., 2020), students (particularly UME students) and HCPs alike indicate that they lack the knowledge on how to take action to address the SDOH, not necessarily within their practice and direct patient care, but in the realm of policy change (Hayman et al., 2020; McIntyre et al., 2013). From these findings, it appears that students feel that they are underprepared to address the SDOH in practice, and both students and professionals feel that

attempts to address these in the clinical setting are futile as they do not actually change the up-stream factors that contribute to health inequities (Hayman et al., 2020; McIntyre et al., 2013). As such, some educators have worked towards a program model for educating on the often-cited CanMEDS[14] competency of physicians being leaders and advocates (Benrimoh et al., 2016). Additionally, the seminal document within UME regarding SA—the *Global consensus*—has indicated the need for advocacy and broader "health-related reform" as a graduate competency for freshly-minted physicians (2010, p. 6). To meet these goals, institutions have begun to implement curriculum that focuses on health policy and how to write policy briefs and letters that can contribute to direct advocacy for not only patients, but the other two spheres of health advocacy as recognized by Benrimoh et al. (2016): institution-level and population-level advocacy (p.3) (See: Glauser, 2018; Hayman et al., 2020). Others have taken to more forward-thinking curricular approaches by getting students involved in advocacy related projects with community partners (Boroumand et al., 2020). Such work reinforces the need for HCPs to turn to the systemic implications of healthcare to make sustainable change in the way of health equity.

Whose Job is it Anyway?

The last major finding when studying barriers to working as a just and socially responsible HCP by including SDOH considerations in healthcare is the idea that it's not a clinical HCP's job, but someone else's job, namely non-clinical workers such as Social Workers (Chhabra et al., 2019). This came up in studies conducted with current HCPs, mostly physicians, when assessing the use of clinical tools that aimed to improve assessment of SDOH (Chhabra et al., 2019; Naz et al., 2016). This finding is also consistent across international jurisdictions, with

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[14] These competencies are defined in the 2015 CanMEDS framework on pages 20 and 22. Reference: Frank, J. R., Snell, L., & Sherbino, J., (Eds). *CanMEDS 2015 Physician Competency Framework*. Royal College of Physicians and Surgeons of Canada. https://www.royalcollege.ca/rcsite/documents/canmeds/canmeds-full-framework-e.pdf

support of assessment and action on SDOH in clinical practice differing between providers who have extra staff and resources and those who express that time constraints, lack of resource familiarity and lack of support staff inhibits such practices (William-Roberts et al., 2018). Even with the perceptions from physicians indicating that they should not be the primary professionals acting on SDOH or working towards mitigating health inequities in clinical settings, attempts to educate HCPs (including but not limited to physicians) on assessing and addressing SDOH in practice continue to be made such as through innovative clinical and residency placements (Abbott et al., 2020; Edwards et al., 2015) and immersive experiential learning during health professions training (See: Biswas et al., 2020; Crampton et al., 2016; Essa-Hadad et al., 2015; Farley & Jacobwitz, 2019; Harrison et al., 2020; Hayman et al., 2020; Hu et al., 2017; Kickett et al., 2014; Lambert et al., 2020; Meili et al., 2011; Nguyen et al., 2021; Patel et al., 2021; Schmidt et al., 2017; Shah & Reeves, 2015; Snyman & Geldenhuys, 2019; Veras et al., 2013; Vikstrøm et al., 2017; Walsh et al., 2020). Thus, there is a demonstrated gap between what physicians are being trained to do and what they may actually be doing in practice.

Alongside physicians, there are several healthcare professions that have significant patient contact such as nutritional specialists, and physical and occupational therapists, whose disciplines have begun to address the need to learn these fundamental concepts during their academic training (Haughton et al., 2013; Veras et al., 2013). However, the literature continues to be dominated by studies focusing on UME. Despite the “not my job” mentality that many of these studies yield from pre-medical students and current physicians, there is a need to broaden the scope and educate not only these professionals, but also other regulated and allied health professions. Given the continuity of health disparities experienced by marginalized groups globally, researchers agree that part of the focus of future directions should be on education, to

inform and prepare socially responsible future HCPs to implement SDOH assessment and considerations into practice (Hayman et al., 2020; Naz et al., 2016; Patel et al., 2021). However, in order to inform future directions for SRSJ-aligned education, stakeholders need to understand current HCPs' and health professions students' perceptions of the training already being provided, and how this translates into effective practice.

Frameworks and Suggestions for Teaching SRSJ

Despite all the models and effort towards teaching HCPs to be just and socially responsible, there are some that claim there's a lack of successful programming happening (Guerra & Kurtz, 2017; Sharma et al., 2018). Thus, the question begs, what approaches might be successful and how should they be implemented?

While many programs related to SRSJ in health professions training focus on particular concepts (i.e. CS, SDOH, Social Justice, Advocacy), there is a disconnect when such concepts are not taught in tandem. Such ideas have been stated multiple times, for example by Kansal et al. (2020) and Beavis et al., (2015) who note that SDOH cannot be taught without critical reflection and questioning of positionality and power dynamics, or as in Hayman et al. (2020) and McIntyre et al. (2013) who purport that although SDOH may be taught, a lack of knowledge about how to properly advocate for those disproportionately affected by them persists. The disconnect occurs when the underpinnings of teaching such curriculum are not made clear (see Table 2 for different concepts associated with SRSJ). For instance, if a competency-based approach is taken rather than a critical cultural approach (see: Reitmanova, 2011), then the intention with providing such SRSJ-aligned curriculum is to make experts on culture– something that often aligns with multicultural or cross-cultural education (Kline et al., 2013). If a critical cultural approach is taken, then the goal of the curriculum is not to create all-knowing HCPs, but

to create critically reflective and self-aware ones who are cognizant of power dynamics and how these play into presence, or absence, of equitable healthcare and health outcomes (Kumagai & Lypson, 2009).

In a literature review conducted by Blanchet Garneau et al. (2021), the incorporation of social justice and equity for Indigenous peoples in health professions training was investigated. Findings indicated that in order to promote such equity and social justice with these students, a particular pedagogical stance needed to be taken– in this case a critical one (Blanchet Garneau et al., 2021). Furthermore, the need to educate the faculty disseminating this information was noted in the 3-phase model they created, (along with adopting critical approaches and creating partnerships with Indigenous communities, students, and educators) (See: Blanchet Garneau et al., 2021, p. 4). Other studies have similarly pointed to lack of faculty knowledge on SRSJ-related concepts as a barrier to successful teaching, and thus the need to educate instructors on said topics in order to fully equip them to teach SRSJ curriculum, as well as to align with its priorities (Benrimoh et al., 2016; Mangold et al., 2019; Thompson et al., 2011).

Because of the disconnect between the different tenets of SRSJ-aligned curriculum, many educators have come to create frameworks related to implementing this curriculum in health professions training– most commonly in UME (posed as SA rather than the more encompassing SRSJ of interest to this study). Despite the focus in UME, there is plausibility in applying such frameworks to other health professions programs as they all either include SRSJ-related concepts in their accreditation standards or in their professional competencies and standards (see above sections titled “Medicine”, “Nursing”, and “Paramedicine”)– thus there is an indicated need for such initiatives (and for them to be effective).

Various papers point to the need to implement SRSJ-related mandates (i.e. SA) and accreditation standards, such that these concepts become not only mandatory learning requirements or competencies, but are ingrained into the institution and even the faculty (see: Abdalla, 2014; Paul et al., 2018; Ross, 2018; Rourke, 2018; Ventres et al., 2016). In one study by Mangold et al. (2019), a group of key informants established a consensus regarding what should be taught at the curricular level in UME to foster SA in future physicians. The main findings indicated that the most important skills to be disseminated were interprofessional collaboration, specifically with community providers, and screening patients on "assets and needs" (Mangold et al., 2019, p. 1356). In terms of attitudes to be fostered, key informants pointed to the need for appreciating the causal relationship of SDOH on health disparities; understanding that "care occurring inside the health system is only a small component of what impacts a patient's overall health status"; and wellbeing as contextualized by "family, culture, community and society" (Mangold et al., 2019, 1356). In addition to this specific knowledge that UME students should learn, it was made clear that longitudinal integration was favoured (Mangold et al., 2019). Lastly, in order to assess acquisition of such knowledge, findings from this study pointed to the need to look outside of the traditional evaluative methods (multiple choice tests, self-assessment questionnaires), and to seek feedback from the community, community health workers, and health improvement measures (Mangold et al., 2019, 1357). This last point plays directly into the prominent idea of "nothing about us without us"[15] that is inherent in SA and social responsibility frameworks. Essentially, all activities undertaken by an institution that claims to be socially

[15] The slogan "nothing about us without us" rose to popularity predominantly in the disability rights movement internationally in the 1980s (Charlton, 1998) and has since made its way into the realm of SA—providing a voice for and a place at the table for the constituents that such mandates strive to serve.

responsible or socially accountable should be community-driven and responsive to the needs of said community.

In addition to what should be taught, the question is: how should these topics be taught? Many articles point to the use of experiential learning as a beneficial tool that connects didactic and clinical learning (Abbott et al., 2020; Denizard-Thompson et al., 2021; Essa-Hadad et al., 2015; Farley & Jacobwitz, 2019; Harrison et al., 2020; Ratcliffe et al., 2018; Walsh et al., 2020). In a literature review by Doobay-Persaud et al. (2019), experiential learning was noted to be pervasive throughout the many SRSJ-aligned models in health professions training, with didactic learning components often being coupled with experiential ones (p. 723). Alongside experiential learning, longitudinal implementation of curriculum is also noted (see: Beavis et al., 2015; Benrimoh et al., 2016; Denizard-Thompson et al., 2021; Goez et al., 2020) as well as integration of SRSJ into courses central to each health professions program (Benrimoh et al., 2016). Suggestions for SRSJ-aligned curriculum topics and examples for implementation have been compiled in Figure 2.

Table 3

Considerations for Curricular Inclusion of SRSJ

Curriculum Components	Examples & Relevant Literature
Health Advocacy	● Knowledge of local resources (see: Behforouz et al., 2014; Benrimoh et al., 2016; Ross et al., 2014); ● How to take action outside of the clinical setting (see: Benrimoh et al., 2016; Boroumand et al., 2020; Nguyen et al., 2021); ● Addressing systemic barriers to health equity (see: Benrimoh et al., 2016; Hayman et al., 2020; Nguyen et al., 2021)
Interprofessional Collaboration	● Working collaboratively with other HCPs and sectors (see: Benrimoh et al., 2016; Kickett et al., 2014; Mpofu et al., 2014; Snyman & Geldenhuys, 2019)
Social Determinants of Health	● Understanding of and application of knowledge regarding SDOH (Allan & Smylie, 2015; Behforouz et al., 2014; Denizard-Thompson et al., 2021; Farley & Jacobwitz, 2019); ● Conceptualizing SDOH as a major contributor to health inequity (see: Mangold et al., 2019; Ventres et al., 2018)
Cultural Safety	● Focusing on client-centred and client-directed care (see: Curtis et al., 2019; Ross et al., 2014); ● Understanding power imbalances as it relates to social position (see: Curtis et al., 2019; Racine & Perron, 2011; Reitmanova, 2011; Van Herk et al., 2011); ● Employing critical reflection and fostering critical consciousness to work towards mitigating power imbalances (i.e. checking personal biases and understanding own position) (see: Halman et al., 2017; Ng et al., 2020; Racine & Perron, 2011; Reitmanova, 2011; Ryder et al., 2019)

Note. This table presents the various concepts arising throughout the literature on instilling SRSJ within health professions students.

For the purposes of establishing consensus as to what schools should be doing to create just and socially responsible HCPs, six sources were referenced specifically for their focus on integrating SA into health professions training (one of which is a commentary piece– Rourke, 2018). Out of these documents five were focused on UME; however, commonalities were seen between the frameworks and studies conducted with various health professions disciplines. As such, the common themes found in the frameworks and suggestions from these articles may also be applied to other health professions programs and other educational initiatives and frameworks (i.e. SRSJ in place of SA).

Among the suggestions and frameworks for implementing SA in education the most common tenets were the following: (1) engaging community in all aspects of the program (i.e.

educational planning, research, evaluation) (Abdalla, 2014; Fung & Ying, 2021; Global Consensus for Social Accountability of Medical Schools, 2010; Rourke, 2018); (2) increasing and diversifying service-learning and clinical education opportunities (Fung & Ying, 2021; Rourke, 2018; Walling et al., 2021); (3) bringing in support staff to educate on topics outside of the profession (interprofessional education) (Abdalla, 2014; Fung & Ying, 2021; Rourke, 2018; Ventres, 2018); (4) integrating SA into other curriculum (not simply as an add-on) (Fung & Ying, 2021; Ventres, 2018); (5) commitment of faculty, staff, and institution to SA (Abdalla, 2014; Ventres, 2018); (6) reorienting education, research, and clinical experiences towards community needs (Abdalla, 2014; Global Consensus for Social Accountability of Medial Schools, 2010; Ventres, 2018); (7) paying special attention to needs of underserved and marginalized populations in educational and clinical applications (Abdalla, 2014; Fung & Ying, 2021; Ventres, 2018; Walling et al., 2021); (8) clearly stating SA in program's purpose, mandate, and objectives (Abdalla, 2014; Rourke, 2018; Ventres et al., 2018; Walling et al., 2021); and (9) admissions policies that prioritize recruitment of students reflective of the local population (Abdalla, 2014; Global Consensus for Social Accountability of Medical Schools, 2010; Rourke, 2018; Walling et al., 2021).

Table 4

Principles for Fostering Social Accountability within Health Professions Programming

Components	**Examples & Relevant Literature**
Community engagement	• Incorporating learning components with local communities (see: Goez et al., 2020; Kline et al., 2013); • Engaging key informants from the local underserved and marginalized communities to inform curriculum (see: Beavis et al., 2015; Essa-Hadad et al., 2015; Kickett et al., 2014; Shah & Reeves, 2015)
Diverse service-learning and clinical opportunities	• Incorporate experiential learning opportunities that connect SA concepts to practical applications and settings (see: Abbott et al., 2020; Biswas et al., 2020; Essa-Hadad et al., 2015; Ross et al., 2014; Walsh et al., 2020)
Including support staff to bolster learning	• Key informants and knowledge keepers to teach particular content (see: Beavis et al., 2015; Essa-Hadad et al., 2015); • Bringing in professionals from other areas to touch on IPE (see: Fung & Ying, 2021; Mpofu et al., 2014; Ross et al., 2014)
Integrating social accountability into existing curriculum	• Integration into core courses (see: Fung & Ying, 2021; Forsyth et al., 2019a; Goez et al., 2020; Reitmanova, 2011)
Faculty, staff, and institutional commitment to social accountability	• Aligning of objectives to work towards SA (see: Paul et al., 2018; Rourke, 2018); • Ensuring staff are trained on SA and can incorporate it into the training (see: Mpofu et al., 2014; Ross et al., 2014; Ross, 2018; Thompson et al., 2011)
Addressing community needs through education, research, and clinical experiences	• Create initiatives that specifically work towards addressing these gaps in care (see: Boroumand et al., 2020; Nguyen et al., 2021); • Involve marginalized and underserved communities in clinical components of education (see: Kline et al., 2013; Ross et al., 2014; Walsh et al., 2020)
Incorporating information relevant to underserved and marginalized populations' needs during both didactic and clinical learning	• Exposing students to relevant information in the classroom (see: Forsyth et al., 2019a; Shah & Reeves, 2015; Snyman & Geldenhuys, 2019); • Incorporating learning of such information into clinical experiences (see: Snyman & Geldenhuys, 2019; Wilson et al., 2020); • Incorporating learning of such material in innovative ways (see: Kickett et al., 2014; Shah & Reeves, 2015; Uy & Dimaano, 2020)
Emphasizing social accountability as a main tenet of the program	• Stating SA in program's purpose, mandate, and objectives (see: Abdalla, 2014; Ross et al., 2014; Rourke, 2018)
Admissions policies prioritizing equity, diversity, and inclusivity	• Recruitment of students reflective of the local population (see: Ross et al., 2014; Rourke, 2018; Strasser et al., 2013)

Note. The table compiles the suggestions seen across various papers from the literature review regarding implementing particularly SA within education. SA is used as a popular educational framework within the health professions and as such is used as a guiding framework within this paper (seeing what is done within this framework and what can be modified to promote not just SA, but also the concepts contained within SRSJ as proposed within this paper).

Secondary Literature Review

As stated in Appendix A, a second literature review with a revised search string was undertaken following completion of the data collection and analysis to inform further discussion of the findings. Utilizing the revised search which included SRSJ concepts such as intersectionality, CS, CC, cultural humility, health advocacy, anti-racism, and anti-colonialism, a total of 34 articles were reviewed. Findings from this secondary literature review reinforced findings from the initial review including: nursing and medicine being the main proponents of these concepts within their education systems (see: Brender et al., 2021; Chen et al., 2018; Davis et al., 2021; Gruner et al., 2022; Hariharan et al., 2022; Howell et al., 2019; Hubinette et al., 2014; Li et al., 2022; Morelli et al., 2023; Mundie & Donelle, 2022; Luctkar-Flude et al., 2021, 2022; Novak et al., 2022; Oikarainen et al., 2019; Papic & Ziad Malak, 2012; Schiff & Rieth, 2012; Van Brewer et al., 2021; Vasquez Guzman et al., 2021; Van Brewer et al., 2021); varied approaches to disseminating SRSJ-related content (Davis et al., 2021; Haghiri-Jiveh et al., 2020; Hyett et al., 2019; Luctkar et al., 2021, 2022; Morelli et al., 2023); the role of hidden curriculum in preventing health systems change and transformative learning (Pentecost et al., 2018; Pitama et al., 2018); the importance of role modeling of SRSJ by faculty and clinical staff (Hubinette et al., 2014; Hyett et al., 2019; Pentecost et al., 2018); the importance of reflection on learned content as well as personal values and biases (Mills et al., 2018; Pentecost et al., 2018); and the inclusion of community voices and minoritized voices within health professions education (Gruner et al., 2022; Guerrero et al., 2023; Haghiri-Jiveh et al., 2020; Hariharan et al., 2022; MacLean et al., 2023; Morelli et al., 2023; Van Brewer et al., 2021).

Differing from the initial review, the emergence of curriculum focusing on sexual and gender minorities (SGM) (see: Burcheri et al., 2023; Luctkar et al., 2021, 2022) and people with

disabilities (PWD) (Brender et al., 2021; Doebrich et al., 2020; Morelli et al., 2023) was seen. Additionally, given the revised search terms, studies looking at the implementation of or proposal to implement anti-racist and decolonizing curriculum were seen (see: Came & Griffith, 2018; Hariharan et al., 2022; Novak et al., 2022; Pentecost et al., 2018; Van Brewer et al., 2021). A focus on critical stances to pedagogy was also advocated for in several proposed frameworks and commentaries for implementing SRSJ-aligned curriculum (Came & Griffith, 2018; Pentecost et al., 2018; Schiff & Rieth, 2012). Lastly, calls for more guidance on implementing such SRSJ concepts were seen (Li et al., 2021; MacLean et al., 2023; Ussher et al., 2022).

With regards to varied approaches to disseminating SRSJ content, this second review elucidated studies utilizing various methods such as a virtual simulation game to teach nursing students about SGM health and healthcare (Luctkar-Flude et al., 2021; Luctkar-Flude et al., 2022), critical reflection within UME and nursing education to understand power dynamics and personal values or identities (Novak et al., 2022; Oikarainen et al., 2019), positive space training for community college health professions students to interact with people from the lesbian, gay, bisexual, transgender, two-spirit, and queer (LGBTTQ+) community (Haghiri-Jiveh et al., 2020), and UME and Physician Assistant programs utilizing focus group sessions held by PWD (Morelli et al., 2023).

As evidenced by the different search results stemming from this second review, there are additional points of consideration when examining the current context of health professions education across colonial states. For example, when considering educating on concepts such as anti-racism, Novak et al. (2022) point to the need to cater curriculum or pedagogical approaches to individual students' needs to meet them where they are at. Novak et al. (2022) refers to students as being on a spectrum of critical consciousness, with some students being more

"activated" as compared to others upon matriculation. Findings from the study conducted by Makanjee et al. (2023) indicate that learning critical SRSJ concepts (in this case CS), was positively influenced by lived experience. They relay that learning CS is not done in "isolation" but rather is the result of the interplay between disseminated curriculum, "self-awareness… and… lived experiences" (p. 599). Such findings, although reported regarding diagnostic radiology students, may also be applicable to other health professions students.

Another interesting point brought up regarding curricular initiatives surrounding CS, CC and cultural humility is the resulting attitudinal and behavioural change that results from such curriculum. The resulting literature of this second search relayed the idea that when administering pre- and post- tests following the intervention of a CS or CC course, confidence in ability to provide culturally safe care may decrease. This was seen in one study by Gray et al. (2020) when implementing an Indigenous CS course for Australian allied health professions students. In this study, first year students following the completion of the course indicated that while their cultural knowledge had increased, their confidence to be able to provide culturally competent care had decreased (Gray et al., 2020). This same phenomenon was also noted by Burcheri et al. (2023) amongst Canadian medical residents with regards to learning about SGM patients healthcare needs. In this study, it was found that increased training on particular topics relevant to SGM health resulted in decreased comfortability initiating conversations about sexual history with patients– indicative of a potential increase in cultural humility (i.e. recognizing one's shortcomings with regards to knowledge surrounding SGM health) (Bucheri et al., 2023). Nursing students in the U.S. were surveyed in a study by Chen et al. (2018), with results indicating that the majority White, non-Hispanic female student body was at a culturally competent level (as determined by the Inventory for Assessing the Process of Cultural

Competence among Healthcare Professionals–Student Version (IAPCC-SV©) tool). However, while students were competent, this was due to a higher score within the survey section on cultural desire (i.e. one's intrinsic motivation to become culturally competent) (Chen et al., 2018). While students scored higher on their desire to engage in a culturally competent way, their scores regarding cultural knowledge (i.e. knowledge of other cultures) were low (Chen et al., 2018). Interestingly though, Chen and colleagues (2018) found that those with previous work experience in healthcare settings scored higher on the subsection regarding cultural skill, or being able to seek out and obtain the relevant information required to provide culturally competent care. This last point relates to what Makanjee et al. (2023) pointed out– learning of such concepts is not done in isolation, it is influenced by students' lived experiences and backgrounds. Lastly, an intercultural learning module facilitated between allied health professions students from Australia and Hong Kong indicated similar results with decreased levels of self-perceived cultural competency following the intervention of their virtual course (Hyett et al., 2018). As noted by the authors, this may be due to an increase in critical reflexivity or cultural humility wherein the students question their previous assumptions and realize how little they truly know about another's culture (Hyett et al., 2018). Such humility is essential given reports such as that relayed by Ussher et al. in 2022 wherein Australian oncology HCPs relayed feeling comfortable treating SGM patients despite having low levels of confidence and knowledge regarding this population's health needs.

Despite the negative correlations between confidence to provide culturally safe or competent care and exposure to cultural knowledge, there are positive outcomes as reported by multiple studies regarding such interventions with health professions students (Haghiri-Jiveh et al., 2020; West et al., 2021). In one review by Pitama et al. (2018), a higher time allocation

related to Indigenous health curriculum resulted in students reporting increased ability to work with Indigenous patients and to work towards change in Indigenous health outcomes. Further reports of positive knowledge acquisition were seen in a review conducted by Mills et al. (2018) when health professions students were exposed to Indigenous health curricula that they felt was relevant to their future clinical practice. In the study by Haghiri-Jiveh et al. (2020), health professions students reported positive experiences and increased confidence in addressing homophobic behaviour following their SGM workshop. Findings from this study indicated that such knowledge acquisition led to trickle down effects with students disseminating their new knowledge to community members (Haghiri-Jiveh et al., 2020). Low et al (2021) reported similar finding in their paper regarding educating on transversal competencies[16]. The authors noted that students upon learning and engaging with the curriculum, become the teachers, taking knowledge into the community and participating in a reciprocal nature with their formal educators. This phenomenon is also supported by Novak and colleagues (2022) with regard to promoting anti-racist education and praxis among UME students, utilizing the critically activated student as the changemaker within their community (i.e. the student body). In a review of current health professions CC education across colonial countries (U.S., Canada, Australia), it was found that overall, students who engage in CC courses have increased competency than those who do not (Arruzza & Chau, 2021).

Current Gaps

In the realm of SRSJ, studies do not only focus on health professions students, but also on active HCPs and their practices. These are important to consider as they point to gaps in the

[16] Transversal competencies are "recognized globally as an essential lever in education for 'future proofing the workforce' by the European Commission, OECD and World Economic Forum (Whittemore, 2018)... The UNESCO definition contains six TC domains (critical and innovative thinking, interpersonal skills, intrapersonal skills, global citizenship, media, and information literacy and other)" (Low et al., 2021).

current education of HCPs and what may be needed. Many of these studies are evaluative in nature and assess HCPs' attitudes towards working with certain populations (see, for example: Chhabra et al., 2019; Kirkham, 2003; Naz et al., 2016; Paudyal et al., 2019). In addition, they may focus on assessing the implementation of a new tool and its effects on considering SDOH in clinical practice (Naz et al., 2016; Chhabra et al., 2019). Such studies yield varying results; however, in general barriers to providing just and socially responsible care include: lack of basic knowledge or understanding of key concepts (i.e. SDOH) (Paudyal et al., 2019; Williams-Roberts et al., 2018); lack of resources (or knowledge of resources) (Chhabra et al., 2019; Paudyal et al., 2019); and lack of time and staff (Chhabra et al., 2019; Williams-Roberts et al., 2018). These are all common findings when looking at whether HCPs consider SDOH in their daily patient interactions—a consideration essential for working towards health equity. Additionally, all of these issues compound on one another. For instance, unfamiliarity with resources available to patients is cited as a barrier to providers' comfortability in incorporating SDOH considerations into care (Naz et al., 2016; Paudyal et al., 2019), and lack of resources such as in-clinic Social Workers, may also coincide with HCPs indicating a "not my job" mentality when it comes to assessing SDOH in clinical practice (Chaabra et al., 2019).

Furthermore, while multiple studies assessed students' experiences with particular program models or content, many were quantitative in nature. Such quantitative methods as surveys and questionnaires, while ideal for program evaluation, leave little room for explanation and detail on behalf of the students completing them. On the other hand, some studies have utilized qualitative methods such as individual interviews (Abbott et al., 2020; Beavis et al., 2015; Edwards et al., 2015; Forsyth et al., 2019b; Paul et al., 2018; Ratcliffe et al., 2018), focus groups (Hayman et al., 2020; Ratcliffe et al., 2018), and thematic analysis of written pieces

(Essa-Hadad et al., 2015; Harrison et al., 2020; Haughton et al., 2013; van den Heuvel et al., 2014), and journals (Biswas et al., 2020); however, they tend to separate the student from the experience– not considering gender-based or sex-based analysis, ethnic or cultural influences on acquisition and comfortability with SRSJ-aligned knowledge, or other demographic factors. When assessing students' perceptions of SRSJ curriculum (e.g. CS and SDOH curriculum), pedagogical styles, and informational attainment, studies are primarily survey-based, and when these studies do include qualitative assessment tools, they do not consider the intersectional identities of the respondents. This lack of detail in the study constructions is part of the reason that the majority of them call for continued evaluation to determine whether the curricular interventions and programs are successful in their design and dissemination techniques. Verbree et al. (2023) also acknowledge that little work has investigated the phenomenon of UME students' perception of their preparation to work with diverse populations and that this area warrants more attention. The same could be argued for other health professions such as paramedicine where literature on this curricular focus is sparse (Harrison et al., 2020; O'Meara et al., 2017), and nursing, where there continues to be a lack of direction for instructing nursing students on certain SRSJ-related topics (Doobay-Persaud, et al., 2019; Nour et al., 2023). Many of the studies are basing the assessment of students' knowledge on a competency-based system, characteristic of the biomedical model in which the health sciences are based (Morcke et al., 2013). In one study, the composition of the participants is noted as being majority female, yet no inquiry into the reasoning behind this is conducted, simply a note that future research should consider the implications of such participant demographics (i.e. whether only female participants would be interested in discussing their experiences with SRSJ-aligned curriculum, whether

female participants have more stake or more interest in SA initiatives in general, etc.) (Walsh et al., 2020).

Additionally, despite the plethora of studies pointing towards inclusion of and frameworks for implementing SRSJ within health professions education, there appears to be a dearth of literature that is specific to such considerations outside of UME and nursing programs within the Canadian context. This leaves a gap of information surrounding similar efforts within other HCP training programs

Inclusion of SRSJ in curriculum (usually on CS and SDOH) is very common throughout the literature, but ranges depending on the program or even the specializations within a program of study (e.g. Global Health). There is no standard in what should be taught, how it should be taught, or by whom. Despite this lack of direction, many health professions training programs have adopted curriculum that touches on these areas, yet there is a mix of results in how students are impacted by this curriculum, and its different models of implementation (see: Abbott et al., 2020; Allen et al., 2013; Biswas et al., 2020; Crampton et al., 2016; Denizard-Thompson et al., 2021; Dickson & Manalo, 2014; Essa-Hadad et al., 2015; Harrison et al., 2020; Patel et al., 2021; Shah & Reeves., 2015; van den Heuvel et al., 2014). In addition to these mixed findings, with the limited amount or lack of research looking into inclusion of this curriculum in other health professions programs, there is a significant gap in the literature. There is a need to disseminate this knowledge to future HCPs, but there is also a need for guidance on wise practices for teaching such topics.

Research Questions

In an attempt to better understand the impact of implementing SRSJ initiatives in northwestern Ontario (NWO) health professions training programs, this study's research

question was: "do health professions students feel that their education has adequately informed, prepared, and encouraged them to work as a just and socially responsible HCP?"

Methodology

To answer the guiding research question, a qualitative methodology was utilized. In the following sections I discuss my positionality, choice of methodology and reasoning for this choice, as well as the specifics of my procedures.

Positionality[17]

Essential to the qualitative research process is the active reflection and positioning of oneself in the research environment (Sword 1999; Finlay, 2002; Creswell & Poth, 2017). To position myself more accurately in relation to my work and to reflect on the process of conducting research and acquiring knowledge, I must first identify who I am; the positions I hold in relation to my research and social standing; and my background as it relates to the formation of my identity and ways of knowing. Only after this will I reflect on the epistemology and ontology with which I have designed my study, as my identity and beliefs inherently contribute to the ways in which I believe the study should be structured and conducted. As posed by Finlay (2002) and Carter & Little (2007), the rendering of positionality and the inclusion of reflexivity throughout the research process also allow the readers to understand and assess the rigour of a study more wholly.

At a surface level I identify and am perceived as a White, cis-gender, heterosexual, able-bodied female descendant of settlers on Turtle Island (commonly known as North America).

[17] This section is largely taken from an unpublished piece written for HESC 5035: Qualitative Inquiry taught by Dr. Levkoe, PhD at Lakehead University during the Fall 2021 semester. Reference: Harvey, A. (2021). *Reflexivity & Position Statement.* Unpublished paper.

Beyond this I am a young, middle-class academic (within this identity itself are my identities as a researcher, educator, and lifelong learner). Lastly, I identify as an ally[18] to marginalized populations and populations made vulnerable. Being an ally in my opinion means advocating for others not only to work towards a common interest, but also to work towards equity for those with whom you may otherwise have no unifying interest. Furthermore, in my experience allyship entails becoming comfortable in the discomfort that arises when working towards equity for vulnerablized populations. Allyship is about recognizing basic human rights and working towards access to basic services and resources—and in this way involves promoting social justice rather than promoting equity alone.

Though I feel that I have not had much professional experience that has allowed me to build my background and identity, I have worked as an English instructor and Health Educator, both of which have continued to fuel my passion for education (both learning and teaching). Through my position as a volunteer-educator who works with newcomers to Canada, as well as through my choice of degree program (focusing on northern and Indigenous health), I find that if I am not able to directly contribute and work with peoples who identify as being part of a marginalized group, I strive to educate myself to better understand their experiences and their implications—as diverse and individualistic as they are.

Despite how I identify now, my upbringing, the environment, and the educational system I was raised in did not make me this way. Rather, the meaning perspectives[19] I held prior to embarking into qualitative research, and more specifically into graduate training were

[18] Allyship as described in the Indigenous Allyship Toolkit (2019) is "about disrupting oppressive spaces by educating others on the realities and histories of marginalized people" (The Montreal Urban Aboriginal Community Strategy Network, 2019).
[19] As per Mezirow (1992): "Meaning perspectives refer to the structure of assumptions within which new experience is assimilated and transformed by one's past experience during the process of interpretation" (p. 2).

constructed through a limited and uncritical perspective and reconfirmed through subsequent education (i.e. consistently reaffirming biases through my undergraduate training) (see: Mezirow, 1990). This is something that I often reflect on and something that has pushed me to challenge myself and to take a critical lens to my work and daily life.

In addition to my educational background, I have goals of continuing to work in the academic sector as well as the health field. Because of this, I am a current graduate student and aspire to one day work as a clinician-scholar. Both of these goals have influenced the focus of my thesis on education of health professions students. However, the nature of my work has also influenced my goals and the reason why I continue towards the path of academia and healthcare.

Previously I had strongly identified as someone working towards equity in healthcare and health education, however through my graduate training, what I now realize is that I am instead working towards practice transformation to reach these goals. As a researcher, learner and educator, I envision my work as something that can and should educate others; as a *critical* researcher, I believe, as Holmes et al. (2008) states "that the knowledge developed in [my] research may serve as a first step towards addressing… injustices," and as such should be challenging the very notion of truth (p. 43). Furthermore, as an ally to and educator of peoples from marginalized groups, who has recently gained a better understanding of my own position in society, and someone who again, associates heavily with academia, I have come to focus my research interests on education. Being brought up and educated in systems that perpetuate systemic oppression (i.e. perpetuating systemic racism, sexism, etc.), I now see that my reason for looking into education is not solely my passion for education, but to work towards improvement and transformation in this vital area– specifically looking at change in health

professions education. In light of this new identity and goal of practice transformation, I have taken a critical lens to the field of education—prompting my study construction.

Reflections on Epistemology, Ontology and Methodology

As a researcher who believes that knowledge is bound to the situation, the context and time in which it is created, and that it is influenced by the nature of the environment in which it is acquired and by those disseminating and receiving it, I based this study on a social constructivist ontology (Creswell & Poth, 2017; Labonte & Robertson, 1996). Additionally, as someone who strives to be self-aware, I recognize that my social position comes with specific perspectives and ways of knowing. Thus, findings should be read through the contexts in which they are garnered and analyzed—as that is how they are interpreted by myself, as the researcher.

Social constructivist paradigm

Given that I believe knowledge is bound to its context, this study was constructivist in nature. This epistemology is underpinned by the ontological view that there is not one subjective reality, rather there are multiple (Creswell & Poth, 2017). As the object under study was students' perceptions of their preparation to be just and socially responsible HCPs, there are many factors that may influence perception. Factors that are found to influence transformative learning and critical thinking (both of which are critical to learning SRSJ-aligned curriculum) include employment of critical self-reflection (Kansal et al., 2020; Mezirow, 1990); challenging of current knowledge (Mezirow, 1990); and personal experience (Mezirow, 1990). Thus, a social constructivist paradigm is ideal for understanding these perceptions as it posits that "subjective meanings are negotiated socially and historically…they are not simply imprinted on individuals but are formed through interaction with others… and through historical and cultural norms that operate in individuals' lives" (Creswell & Poth, 2017, p. 24). This definition accounts for the

various influences that may impact each student's perception of their preparation to become just and socially responsible.

Constructing my study in this way allowed me to account for multiple realities or subjective meanings as (Creswell & Poth, 2017). It also supported the idea that the phenomenon under study and the findings from the study are not generalizable but subjective and particular to those engaging in the research and the time and place in which their experiences occurred. This is especially important to consider as an implication for this work and future similar work—the student experience and their identities should be considered when examining educational efforts (e.g. program evaluation studies). Considering the students' identities, perceptions and experiences is important in understanding the subjective nature of educational preparation.

Case study

Keeping with social constructivism, the methodology focused on understanding the phenomenon under study within its context (Creswell & Poth, 2017). Because of this, the research used a qualitative case study methodology (Baxter & Jack, 2008) which aligns well with this paradigm– contextualizing the phenomenon within its "case" and facilitating exploration of the phenomenon from a "variety of lenses… [allowing] for multiple facets of the phenomenon to be revealed and understood" (p. 544).

Additionally, qualitative case study methodology has been highlighted as ideal for research in education as it is often used for program evaluation (Yazan, 2015). According to Merriam (1998) "as long as researchers are able to specify the phenomenon of interest and draw its boundaries … [of] what they are going to inquire, they can name it a case," (as cited in Yazan, 2015, p. 139). Thus, this methodology may be used to study a group, "a process", or, as is the case in this study, "an institution" (Yazan, 2015, p. 139). As such, given the aforementioned gaps

and considerations from current studies, this study took a critical stance in evaluating the academic preparation of health professions students to work with diverse populations, through the personal accounts of those enrolled in healthcare-related programs at two different NWO institutions. This approach allowed students to voice their opinions regarding their programs in an anonymous fashion, providing a space for these participants to also reflect and critically examine their experiences in tandem with the researcher.

The use of a multiple case study methodology was ideal given the various levels of each case that are to be upholding SRSJ in practice according to guidelines and frameworks published previously (predominantly on SA) (see for example: Boelen, 2000; Paul et al., 2018; Rourke, 2018). However, the use of a case study methodology was challenging given that one of the programs (BScN) was later found to be a collaborative program in which students enrolled in that program could choose to move between the institutions (i.e. cases). It was originally thought that the collaborative students were assigned to one institution or the other, not switching between the two or taking courses at both institutions at the same time. This road bump was encountered early on and as such I was able to modify the research approach slightly when engaging with participants enrolled in the collaborative BScN program (e.g. asking them to clarify which institution they were referring to in interview responses and whether the majority of their experience in the program was at one institution versus the other).

In light of the critical nature of this study, students' perceptions of their preparation to work with diverse populations were not assessed based on competence (i.e. through quizzes, questionnaires, or case scenario prompts). Rather information regarding individual experiences with curriculum and initiatives within their respective institutions and academic programs was collected through individual interviews. The rationale behind this decision was based on findings

from the literature review that concepts such as SRSJ should be embodied across different levels of the institution in which health professions students are taught (i.e. institutional, faculty initiatives, and program curriculum), and thus students may have been exposed to SRSJ concepts in various ways creating different effects (Eslinger, 2013; Ross, 2018). There are also many factors of one's identity that affect acquisition of and experience with certain curricular concepts. Due to this, this study was not seeking to draw hard conclusions that can be generalized across contexts, but rather seeking to illustrate how SRSJ are being taught in these two institutions and potentially to provide wise practices or, at a minimum, considerations for fostering learning of the concepts. Learning of such concepts is bound to the context in which it is taught, and often constrained by outside factors such as community needs, student backgrounds, time constraints, and the pressures of competency-based evaluation systems. To reflect the interplay between institution and learner, research questions considered institutional commitment to SRSJ as well as learner identities and backgrounds. Findings reflected the influence of such factors on the uptake and understanding of SRSJ by the students who participated in this study.

This study utilized a qualitative case study approach informed by Baxter and Jack (2008). The two institutions under study were presented as individual case studies– with participants recruited from various health professions programs. Each institution was defined as a case to contextualize the setting in which learning of such concepts takes place. This is important as the literature indicates that promotion of SRSJ-related concepts must be apparent at the institutional level as well as the departmental, faculty, and curricular levels (e.g. through SA mandates with clear objectives and goals) (see Table 4). Literature also points to the fact that CS and other concepts related to SRSJ need to be not simply learned, but embodied by faculty, staff, and the institution in order to be effective (see: Boelen, 2000; Taylor et al., 2022). Constructing each

institution as a case allowed for better elucidation of how uptake of such concepts is fostered or inhibited. Again, this study was meant to provide another perspective for understanding what helps or inhibits the learning and uptake of SRSJ, in the absence of cohesive curricular approaches, definitions, and pedagogical practices across health professions programs.

Prior to starting any data collection, Ethics approval was sought from and granted by the Lakehead University Research Ethics Board (REB), Confederation College Ethics Board and from the Associate Dean of the Office of Undergraduate Medicine within the NOSM University.

Setting

Participants were recruited from two post-secondary institutions situated within NWO. In this region, an increasingly diverse population is seen (see Patel et al., 2019; Statistics Canada, 2021a; Statistics Canada 2021b) alongside persistent issues of healthcare disparities and of HCP retention (Ontario Medical Association, 2021; Ross et al., 2014). As mentioned previously in the Background section, the major urban hub for this region is the city of Thunder Bay, which has the largest proportion of Indigenous people in Canada (Ontario, 2020), and which serves as a major source of healthcare services and educational opportunities (for example, the post-secondary programs discussed in this study). However, major health disparities for and discrimination against Indigenous populations exist within the city, and warrant recognition when talking about the importance of educating health professions students to be just and socially responsible HCPs (see: Brar et al., 2020; Burnett et al., 2020; Galloway, 2019; Rinne, 2021; Vis, 2021). Selection of this locale and population was also informed by various studies correlating certain pedagogical models (e.g. place-based learning) with improvement in workforce retention and understanding of SDOH (see for example: Crampton et al., 2016; Mpofu et al., 2014; Murray et al., 2012; Ratcliffe et al., 2018; Snyman & Geldenhuys, 2019)– two key

areas critical to providing just and socially responsible healthcare and ultimately improving health outcomes in this region (Ontario Medical Association, 2021; Ross et al., 2014).

Target Population and Sampling

This study recruited students from health profession programs in two different post-secondary institutions.[20] The first institution was Confederation College, where students from nursing (both Practical and Collaborative Bachelor's) and Paramedicine programs were recruited. The second institution was Lakehead University, where students were recruited from the medicine and nursing programs (both Collaborative and Compressed Bachelor's). Participants from these programs were recruited in particular because they are the professions that people in this region most often encounter in their contact with the healthcare system. A total of 4-6 students from Lakehead University and 6-9 from Confederation College were sought for interviews.

Inclusion criteria for interviews were: health professions students in any of the aforementioned programs at each respective institution. Participants needed to be English speakers, and at the time of interview be enrolled at least part-time in their program. Senior class standing students were sought as research participants and preference was given to students who had been enrolled in their program for longer than one academic year. Participation was however possible also for students who had been in their programs less time

Recruitment

Several different recruitment methods were used. Firstly, informational flyers containing instructions to contact the primary investigator (PI), Alexis Harvey, with intent to participate was

[20] It is important to distinguish that during the writing of this research proposal, the Northern Ontario School of Medicine (NOSM), which was originally within Lakehead University, became its own institution. However, NOSM's facilities and faculty still have ties to Lakehead University and as such the medical program will be considered to be housed within the case of Lakehead University.

sent out electronically through the Lakehead University Student Union (LUSU) newsletter as well as various other outlets such as the Lakehead University Nursing Association (LUNA). Said flyers contained a QR code linked to a Google Form through which interested parties could fill in their information to be contacted by the PI to set up an interview (see Appendices B, C, and D). This process took the initiative off of recruits so that all they needed to do was to input their contact information to indicate their interest. Once prospective participants indicated their interest, they were contacted by the PI and sent the information letter (see Appendix E). Departmental coordinators, Administrative Assistants, and professors (where contact information was accessible) were all contacted with requests to disseminate study information and the same flyer (see Appendices F, G, H and I). Lastly, the same flyer was approved and posted in spaces on both campuses to further recruit students. Recruitment efforts were completed as outlined; however, due to institutional processes and policies for advertising on campuses and contacting students, barriers to fully realizing the intended recruitment protocol arose. Due to this, much recruitment took place via snowball sampling (see Appendix K) and via class presentations (i.e. requesting five minutes of time in a class to recruit potential participants). Recruitment presentations were completed in a total of 2 undergraduate nursing courses at Lakehead University, as well as in 4 Practical Nursing courses, 2 Collaborative Bachelor’s of Nursing courses at the College, and 2 Paramedicine courses at the college.

While REB approval was sought from all three institutions involved, the ethics processes were not equally clear to all faculty, departmental staff, and REB staff in the participating institutions. Due to such discrepancies, individuals within each case served as gatekeepers, “arbitrat(ing) access to a social role, field setting, or structure” (Harvey, 2023). Such

discrepancies in guidelines led to a delay in research initiation and further delays in the recruitment of potential participants (i.e. students).

Despite having been granted approval for the recruitment methods outlined in the REB application, many obstacles were met. For example, when reaching out to faculty at NOSM University via email to recruit students, little support was provided. It was not until the Office of Undergraduate Medicine (office through which ethics approval was granted) was copied on an email that it was explicitly made clear that recruitment strategies were to follow a particular protocol—a protocol that was not relayed upon granting of approval to proceed with the research. It should also be noted that I did not receive a formal ethics approval letter. Rather a simple email indicating approval to conduct the study was sent to the PI (Alexis Harvey). This led to further delays as no information was provided as to who could be contacted for recruitment and how researcher-institution relations should be navigated.

Further examples of gatekeeping included lack of updated faculty directories, diverting of responsibility to respond to requests for recruiting initiatives to Deans and upper-level faculty, and the apparent need for professional connections and vetting to gain credibility and access to students. For example, many faculty at the college did not have contact information listed on their departmental webpage. In terms of diverting responsibility to upper-level faculty and departmental staff, this was evidenced via lack of recognition of institutional REB approval of my research recruitment protocols, such that faculty and staff were unsure of when they were allowed to interact with me as an outside researcher. Despite all the barriers met at the college, recruitment was successful—though it was only after direct involvement from key faculty at the university getting involved and vouching for the research and PI. After such connections were

established, emails were facilitated rather rapidly and towards the end of the Fall semester in-class recruitment presentations were conducted.

While recruitment was successful and resulted in a sufficient number of participants, such barriers led to significant changes in the timeline of the research. Data collection was intended to be conducted from September 2022 to October 2022, collection took place from October 2022 to late December 2022.

Data Collection

The data collection methodology consisted of walking interviews with audio recording, Zoom interviews with audio recording, and self-recorded responses (see Appendix M). Semi-structured interviews were conducted with participants in order to get a deeper look into their individual experiences with curriculum and program initiatives that aligned with SRSJ. An interview guide was developed based on the research questions and recommendations from previous studies (see Table 4).

Prior to each interview, participants were provided an information letter containing the details of the study, how they could expect to be treated, and where and how the information they share was to be used. This letter also detailed their ability to withdraw themselves from the study for any reason at any time prior to the anonymization of the data (see Appendix E). Completion of the consent form prior to the commencement of the walking interview, Zoom interview, or self-recording of responses was mandatory (see Appendix L). Notes were taken on a word document following the interviews and saved to the PI's password-protected USB for safe data storage. Zoom meetings were also audio recorded and saved to a different password-protected USB.

Interview questions addressed the following: what curriculum each participant had been exposed to; how SRSJ had been taught to them (e.g. experiential or course-based curriculum); what their definition of health equity was; as well as whether they perceived the aforementioned concepts were an explicit goal of their program, embodied by the coursework, faculty, and particular institution; involvement in advocacy work, activism, community organizing, and volunteering. To determine whether certain curricular models and initiatives result in different perceptions of preparation, questions related to particular course features were asked (see appendix J) and lastly students were asked about their individual identities (inclusive of gender, ethnicity, previous education, and other personal identities they strongly identified with).

Interview Methodology

Interviews were conducted either via Zoom or in-person as "go-along" interviews (Carpiano, 2009) on their respective campus. The "go-along" interview entails following the interviewee in their natural environment—in this case their academic institution, where a walking interview took place given the participant's indication of comfortability with meeting in-person. Where accommodations due to weather or personal preference were indicated, interviews were conducted as a sitting in-person interview (rather than go-along or via Zoom). All in-person interviews were audio recorded except for one, where handwritten notes were used in lieu.

Data Saturation

Interviews were conducted until at least 2 participants had been interviewed from each academic program or until data saturation– specifically inductive thematic saturation—was reached across both cases, whichever came first. Inductive thematic saturation is indicated by the absence of newly emerging themes (Saunders et al., 2018). This saturation technique was ideal as emergent coding was used during the thematic analysis of the interview data.

Thematic Analysis & Pattern Matching

Thematic analysis is purported by Peel (2020) as one way for working with data for applied educational research. Furthermore, they state that thematic analysis “involves qualitative data collection from multiple sources of information and a manageable, flexible thematic analysis process that identifies patterns of meaning within data for interpretation,” thus making it ideal for the type of data garnered through this study (Peel, 2020, p. 13). Following the process of thematic analysis informed by Baxter & Jack (2008), interview transcripts were coded to organize the findings from participants into decipherable themes through the use of Nvivo software. Data analysis was conducted as the interviews were transcribed, via emergent coding, and following transcription as the interviews were read multiple times to become “close” to the data (Richards, 1998). Once themes were identified, and no new themes emerged, inductive codes were compared with the themes found through the literature review. Further, interview data was cross-referenced with curriculum outlines of courses involved in the participants’ programs of study; initiatives of programs they were enrolled in; and any other information pertinent to their case relating to just and socially responsible curriculum and initiatives (institution that they attend). Though these other documents gathered via environmental scan were not systematically coded using the Nvivo software, they were included in order to contextualize the setting in which the student experiences were taking place. Essentially, this adaptive triangulation (Carter et al., 2014) method was used to support or refute the findings found in the interview data. In other words, the documents found via environmental scan contextualized the experiences participants reported during the interviews, strengthening or challenging findings from the emerging themes.

The use of a priori codes for thematic analysis closely aligns with the idea of pattern matching as described by Yin (2014). This technique entails the matching of themes that arise from the data to the propositions established prior to data collection. While propositions were not established at the outset of this research project, themes collected through the literature review served as pre-established themes to which emerging codes from the data were compared (e.g. longitudinal curriculum resulting in better acquisition of SRSJ-aligned knowledge; dismantling of hidden curriculum leading to better learning experiences, etc.). The thematic findings from the literature review were used as established patterns in lieu of propositions, as Yin (2014) advocates for, in order to allow for more inductive analysis of the data. Such an approach was taken in an attempt to better adhere to a constructivist ontology (Shannon & Hambacher, 2014).

A Look at the Cases

An environmental scan of the current policies and frameworks aimed at SRSJ contextualizes the learning environments investigated within this study.

Institutional Policies and Mandates: Lakehead University

For the Lakehead University (LU) case, the 2018-2023 (now extended to 2025) Strategic Plan contains a framework with the following components: academic excellence, entrepreneurship and innovation, social responsibility, capacity development, and local and global partnerships (Lakehead University, 2018). Of particular importance here is the mention of social responsibility, which is defined here as the "commitment to social justice and… mak[ing] a significant contribution to our communities and society as a whole through our programs, research, and the wide range of activities undertaken by our faculty, staff, students and alumni" (Lakehead University, 2018, p. 11). In this document, LU indicates that their commitment to social responsibility means a commitment "to access and equity to postsecondary education, and

to supporting diverse learners achieve their potential” (p. 15). Under objectives for this framework component is the following: “reflect[ing] diversity in our faculty and staff, student body, programs, and curricula; support[ing] Indigenous and other underrepresented student groups to succeed at university; develop[ing] highly skilled, socially aware graduates; foster[ing] greater understanding of societal and environmental issues, and inspir[ing] action for positive change” (p. 15). It is also indicated that LU will develop and implement a “social responsibility education framework… to measure progress in addressing community and societal needs” (p. 15). Of note, no such standalone document could be found such as that seen for the Equity Diversity and Inclusion Action Plan 2019-2024, Research Plan 2019-2024, Sustainability Action Plan 2019-2024, and Academic Plan 2019-2024.

Alongside this, the partnerships piece of the strategic plan relays that the university “will develop informed education, research and service strategies and opportunities through connections with local and global partners, and relationships with Indigenous partners” (Lakehead University, 2018, p. 11). To do this, the plan indicates that LU will establish the “Gichi Kendaasiwin Centre, a community hub that will reflect and celebrate the culture of Indigenous communities in the region, support Indigenous learner pathways to education, and provide support for work placement, training and skills development in Northwestern Ontario” (p. 17). Additionally, there is mention of “increasing the number of research partnerships, co-op placements and work-integrated learning opportunities with municipalities, local government organization, industry and other organizations; expanding partnerships with local, remote and provincial Indigenous groups; developing partnerships with regional school boards and Indigenous education councils to create effective pathways to postsecondary education for people who face economic challenges, or who are from under-represented populations;

collaborating with regional education partners to increase participation of under-represented students in specific disciplines and programs" (p. 17).

When measuring LU's strategic plan progress, the 2022 report indicate that from 2017 to 2022, the social responsibility metric of having a student body reflective of the local and regional demographics and diversity was achieved all five years (Lakehead University, 2022, p. 3). Another important metric relevant to this study is that of an increase in the number of Indigenous faculty. While in the 2017/2018 academic year there was a noted under development in this metric for LU, across the following 4 years (2018-2022) the annual target for this increase had been met (Lakehead University, 2022). The last important metric within the social responsibility category was that of an increase in Indigenous student enrolment. While the annual target had been achieved for this increase from 2017 to 2019, the following years indicated that progress had been made, but that it may have been hindered by the COVID-19 pandemic (for years 2019-2022), resulting in a failure to reach the annual target increase (Lakehead University, 2022).

Measurements of LU's strategic plan progress within the local and global partnerships parameter indicate that the targeted increase in the number of local, national and international partnerships as well as the targeted increase in enrolment of under-represented student groups to specific programs were both met across all 5 years (2017-2022) (Lakehead University, 2022). With regards to the targeted increase in the number of partnerships with Indigenous groups, there was a noted under development in the 2017/2018 academic year, however targets were met across all subsequent academic years (2018-2022) (Lakehead University, 2022). A further notable mention within the 2018-2023 Strategic Plan Year 4 Annual Report document was that "100% of undergraduate students have an experiential learning opportunity" (p. 7).

Another important document from LU is the 2019-2024 Academic Plan. Within this document again is listed the priority of a commitment to social responsibility as well as Anishinaabe Miikana Gichi Kendaasiwin (roughly interpreted to mean Anishinaabe pathways to higher knowledge and education) (see: Lakehead University, 2019, p. 12). Additionally, it is reaffirmed that LU is committed to advancing the Truth and Reconciliation Commission Calls for Action to “provide a more equitable future for Indigenous people” (p. 20). There is a recognition within this document for a continued commitment to the Indigenous Content Requirement “which ensures all graduates of Lakehead University have been exposed to Indigenous worldviews through the program curriculum, and to enhancing Indigenous programming across disciplines” (p. 20). A need to continuously develop intercultural competence among “all levels” of the institution is also noted, particularly with a focus on being able to support Indigenous members of the institutions (i.e. students, staff, faculty, partners and communities) (p. 20).

To support such initiatives, the 2019-2024 Academic Plan states that LU will “support and expand Indigenous programming and curriculum content at both the undergraduate and graduate levels; continue to embed experiential learning opportunities into all programs, including land-based learning and community service learning that reflects Lakehead’s commitment to social and environmental justice and sustainability; develop and implement strategies across all disciplines to promote… social and civil skills development inside and outside the classroom, including the development of intercultural competencies” (p. 23). Additional strategies include “provid[ing] skills-based training in intercultural competencies and diversity, equity, and inclusion to all faculty and staff in support of developing a more inclusive

university culture and learning environment; [and] review[ing] Lakehead's approach to student evaluation of teaching with a focus on capturing meaningful student input" (p. 23).

The only program across both cases to have *explicit* mandates and guidance unique to their individual program is the UME program at LU. This is not new and not due to their recent independence and formation as a standalone medical university (now recognised as NOSM University), as the UME program was established with an explicit SA mandate– being the first Canadian medical school to do so (NOSM University, 2018). In the NOSM University Strategic Plan (2021-2025) the mission of the UME program is stated as "to improve the health of Northern Ontarians by being socially accountable in our education and research programs and advocating for health equity" (p.5). This strategic plan has five directions. The first direction is to transform health human resource planning, "link[ing] health human resources… to Northern Ontario's needs (Francophone, Indigenous, rural, and urban) with a focus on specialist and subspecialist physician training" (p. 10). The second direction is to advance social accountability. This is envisioned as a "embed[ding] social accountability throughout NOSM University with a focus on measurable, transformative, and sustainable change in health-care systems for Northern Ontario" (p. 14). The third direction is to innovate health professions education– being "recognized across Northern Ontario for developing innovative models of education in Northern, Indigenous, Francophone, rural and remote medicine that lead to well-trained health-care practitioners who stay in the communities of the North" (p. 18). And the final two directions are strengthening research capacity in Northern Ontario and becoming a university.

When looking at the UME program's SA metrics, the following is seen among medical students: 91.3% self-identify as Northern Ontarian (target is 80%); 75.36% self-identify as

women (target is 50%); 31.88% self-identify as francophone (target is 30%); and 15.94% self-identify as Indigenous (target is 20%) (NOSM University, n.d.). Across the faculty, 92.92% self-identify as Northern Ontarian (target is 80%); 44.30% self-identify as women (target is 50%); 25.32% self-identify as rural (target is 40%); 9.12% self-identify as francophone (target is 30%); and 2.95% self-identify as Indigenous (target is 20%) (NOSM University, n.d.).

Institutional Policies and Mandates: Confederation College

Guiding documents, policies and plans were less apparent across the Confederation College (CC) case. One plan related to SRSJ at CC was the Kaa-anokaatekin Strategic Plan 2020-2025. This plan consists of four strategic pillars: access and success, Indigenous learning, institutional excellence and community prosperity. The first two pillars are of relevance to this study. Within the first strategic pillar of access and success is the goal of ensuring all graduates "leave with an appreciation of global citizenship"[21] (Confederation College, 2020).

Within the second pillar of Indigenous learning is the goal of engaging in "meaningful relationship building with Indigenous communities and organizations" wherein CC "build[s] strategies to support the recruitment of Indigenous students following principles of respect, relationships and reciprocity with Indigenous communities, partners and organizations" (Confederation College, 2020). Another component of the Kaa-anokaatekin Strategic Plan 2020-2025 is that "all students and employees experience and understand the Negahneewin Vision"[22] to promote reconciliation across the institution.

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[21] In this document, global citizenship is defined according to the Association of American Colleges and Universities (2015) as: "a critical analysis of and an engagement with complex, interdependent global systems and legacies (such as natural, physical, social, cultural, economic, and political) and their implications for people's lives and the earth's sustainability. Through global learning, students should 1) become informed, open-minded, and responsible people who are attentive to diversity across the spectrum of differences, 2) seek to understand how their actions affect both local and global communities, and 3) address the world's most pressing and enduring issues collaboratively and equitably" (Kaa-anokaatekin Strategic Plan 2020-2025, 2020).
[22] This institutional vision was created by the Negahneewin council, outlining outcomes for Indigenous students and all students following engagement with Confederation College in the spirit of reconciliation. Outcomes vary, but are

Another guiding document within the CC case is the Memengwaa Academic Plan 2017-2020. Within this document, there are four listed academic priorities. These priorities include: increasing student success, implementing and celebrating Indigenous education, cultivating and practicing exemplary teaching and learning, and building and expanding relationships and partnerships. With respect to the second goal pertaining to Indigenous education, there are various suggested strategies. These include: "creat[ing] a committee of Indigenous faulty, experts, staff and students that faculty, staff and students can consult; provid[ing] professional development to faculty so they can effectively provide safe classrooms when facilitating dialogue about Indigenous knowledge; hir[ing] more Indigenous faculty, including for non-Indigenous programs; provid[ing] more general education courses which address social justice and Indigenous world views; increas[ing] Indigenous representation on Program Advisory Committees; creat[ing] designated seats for Indigenous learners in targeted programs; [and] continu[ing] to ensure that Indigenous-centred space, signage and artwork exist across Confederation College" (Confederation College, 2017, p. 9). Relevant to the exemplary teaching and learning goal are the proposed strategies of: "survey[ing] faculty and staff to determine learning needs; continu[ing] to educate and support teachers on how to integrate Indigenous knowledge and teaching methods in classrooms; creat[ing] teaching standards for Indigenous education; incorporat[ing] Indigenous world view in pedagogy and selected course content; encourag[ing] experiential learning opportunities; encourag[ing] land-based teaching and learning opportunities; work[ing] with Program Advisory Committees to expand placement opportunities; investigat[ing] scheduling and timetabling opportunities that could expand placements; investigat[ing] new placement opportunities" (Confederation College, 2017, p. 10).

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seen as dependent on a relationship built between Indigenous Peoples and Canadian citizens upon "common ground through a mutual understanding of history, a shared vocabulary and a rich dialogue" (Negahneewin College, 2012).

The last goal of relevance is that of community relationships and partnerships. Among the strategies aimed at addressing this goal, there are multiple relevant to this study including: "participation in community events; build[ing] new partnerships locally, regionally and internationally; promot[ing] intercultural learning and foster[ing] intercultural competence; actively promot[ing] global citizenship and cultural awareness in the classroom and workplace; [and] provid[ing] cultural intelligence training to faculty and staff" (Confederation College, 2017, p. 11).

Findings

Multiple Case Study

Given this study is constructed as a qualitative multiple case study, findings are outlined according to each case. The use of a multiple qualitative case study methodology allowed for separate analyses of the same phenomenon on two different cases. In using this methodology, multiple factors were able to be considered in the contextualization of the findings including institution-wide mandates, goals, and policies.

It is important to note that students from the Collaborative Bachelor of Science in Nursing (BScN) program have the option of taking courses at either the college or the university. These students were assigned to represent the college or the university according to where they reported having taken the majority of their courses. Additionally, prior to April 1, 2022, the UME program was the Northern Ontario School of Medicine housed within Lakehead University, later becoming NOSM University. As UME students were recruited after having been enrolled for at least one year, students captured within this study were those who were taught previously by the institution while it was recognized as a school of the larger Lakehead

University. Thus, the UME program was conceptualized as a part of this case despite its recent independence and establishment as Canada's first independent medical university.

Interviews

Of the interviews conducted, 15 were go-along, 4 were via Zoom, 4 were conducted in-person, sitting, and 1 was self-recorded. Of the in-person interviews, 3 were conducted outside of the intended locations due to participant preference and scheduling. Of these three, one was conducted on the opposite campus for which the student was enrolled (Lakehead University instead of Confederation College), and two were conducted in community (one in Thunder Bay), and one in a northwestern Ontario town where their clinical placement was taking place.

One participant opted for a self-recorded response. This option specified the requirement of audio recording responses or utilizing talk-to-text software to record responses. Questions did not differ from those asked of the participants undergoing walking or Zoom interviews, however the interview guide did have emphasis placed on certain questions for answerability and prompting for specificity in responses (see: Appendix M).

Use of the go-along interview methodology resulted in students actively reflecting on their time in their programs as they walked through their institution or "case". Some students referred to artwork on the walls of their campus while others showed me where they had some of their classes. While space was not a part of the research question, it played a role in helping students to elaborate on their experiences within their programs while in discussion. Being within the students' academic environments also helped me to ascertain what they are exposed to on a weekly basis as they enter campus to attend class. From my walks through the campuses, I was able to observe posters and flyers, student interactions, as well as decorations and the layouts of the buildings. Having a sense of where particular classrooms were located in

comparison to study spaces, student supports, and representation of different cultures (e.g. through artwork) helped to further inform me as the researcher about what the institutions may be doing to increase students' awareness of diversity and the context of NWO. For example, having a policy regarding inclusion of Indigenous culture in curriculum in writing may also be reflected through how the university or college emphasizes the importance of Indigenous culture on campus by way of artwork, presence within the faculty and student body, as well as support services for Indigenous students. By walking through the campuses with the interviewees, I was privy to the presence or absence of these considerations. While this does not play heavily into the analysis (i.e. exemplifying and contextualizing within the analysis what was seen across the campuses), walking through these spaces with participants appeared to effect their responses—prompting them to remember particular instances, relaying reflections on their campuses, and more. For example, one student mentioned how they really enjoyed the Indigenous artwork that adorned the walls of a particular part of the CC campus, before reflecting on how diverse they felt the student body there is.

Participants

A total of 24 participants were interviewed, of which 11 were from CC and 13 from LU. Demographic information can be seen in Table 5. Due to anonymity concerns, individual identities were not attributed to particular participants and their interview file names. When using quotes from interviews I have used the acronyms that signify which program a participant's quote may be attributed to (e.g. UME is used to signify a student in the undergraduate medical education program, PCP is for a student in the primary care paramedicine program, BSNCOM is a compressed BScN student, BSNCC is a collaborative BScN student from the CC case, and

BSNLU is a collaborative BScN student from the LU). Further breakdown of findings surrounding participant identities can be found in Figures 1-5.

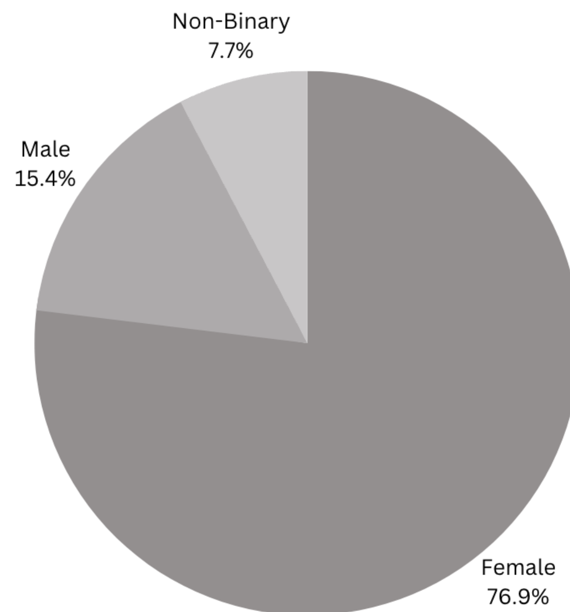
Figure 1

Participants' reported genders for Confederation College

Note. 54.5% of the participants identified as male and 45.5% identified as female.

Figure 2

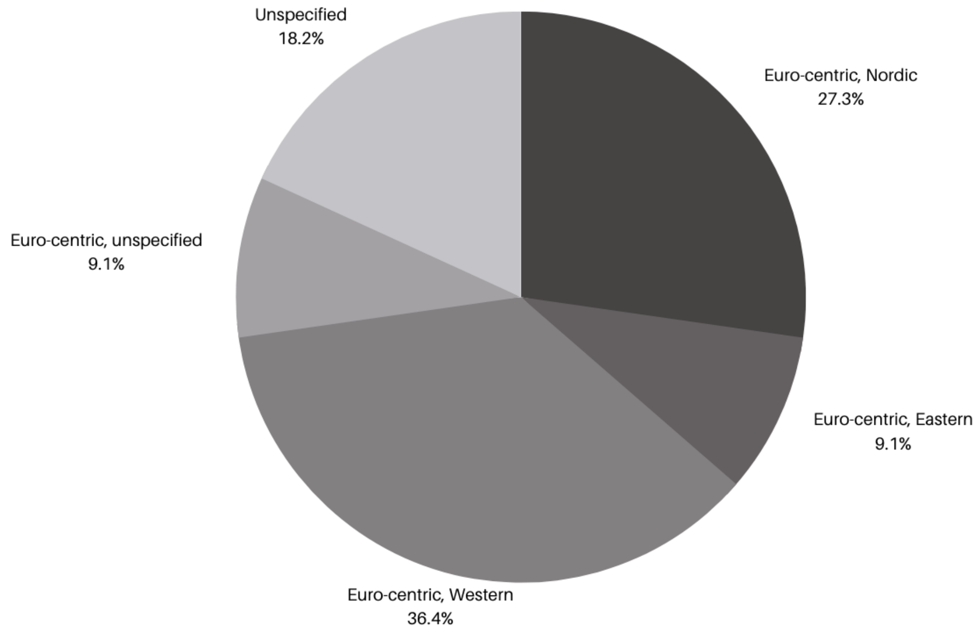
Participants' reported genders for Lakehead University



Note. 15.4% of participants identified as male, 7.7% as non-binary, and 76.9% as female.

Figure 3

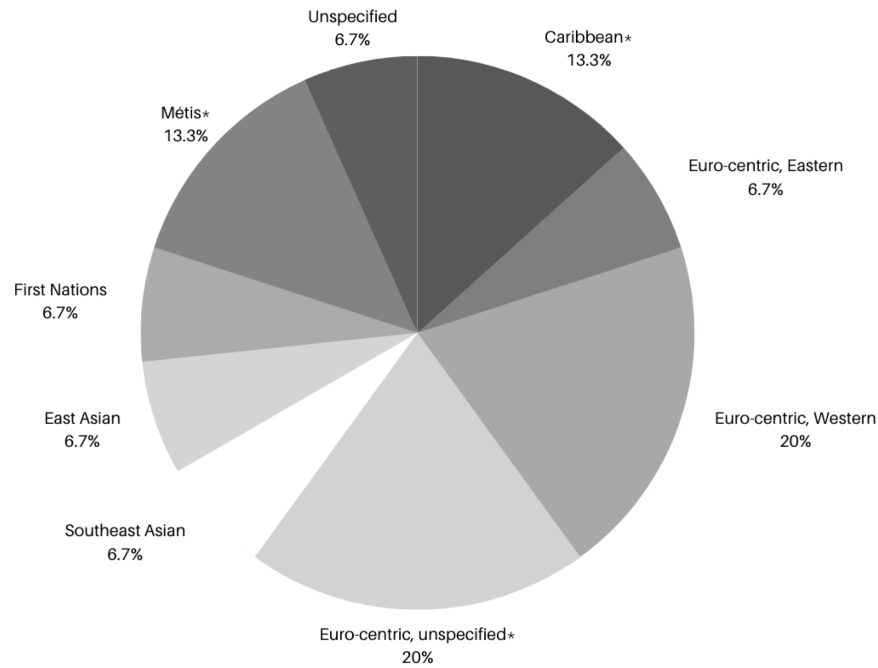
Ethnicities reported by participants from the Confederation College case



Note. Two participants did not elaborate on their ethnicities, represented by the "unspecified" category.

Figure 4

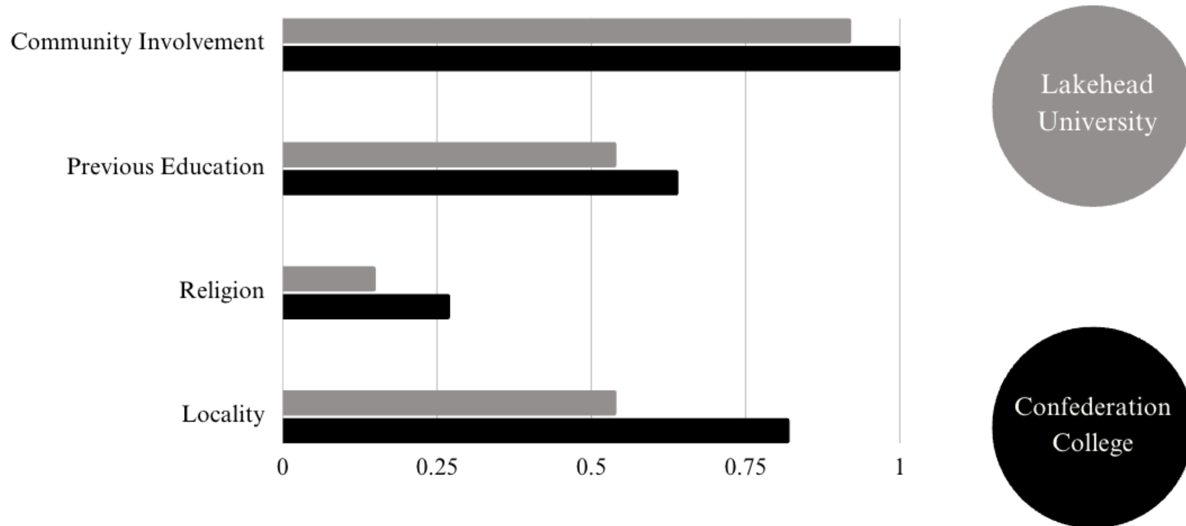
Ethnicities reported by participants from the Lakehead University case



Note. Two participants reported more than one ethnic identity and were counted twice. This is denoted by the asterisks (*).

Figure 5

Participant Identities and Backgrounds



Note. Proportion of students per case who reported holding particular identities. Identities have been placed into broad categories that represent the ideas of being involved in the community via voluntarism, work, advocacy, organizing, etc. (community involvement); having gone through some form of post-secondary education outside of their current program (previous education); having a religious background or having been raised with such a background (religion); and being from the northwestern Ontario region (locality).

Table 5

Participant backgrounds and identities

CASE	PROGRAM	GENDER	ETHNICITY	RELIGIOUS BACKGROUND	FROM NWO	PREVIOUS POST-SECONDARY EDUCATION	COMMUNITY INVOLVEMENT
CC	Collaborative BScN	F	Euro-centric, Nordic	Y	Y	N	Y
	Collaborative BScN	M	-	-	Y	N	Y
	Collaborative BScN	F	Euro-centric, Eastern European	N	N	N	Y
	Collaborative BScN	F	Euro-centric, Nordic	Y	Y	N	Y
	Practical Nursing	F	-	N	Y	Y	Y
	Practical Nursing	M	Euro-centric, Western European	Y	N	Y	Y
	Practical Nursing	F	Euro-centric	-	Y	Y	Y
	Primary Care Paramedicine	M	Euro-centric, Nordic	-	Y	Y	Y
	Primary Care Paramedicine	M	Euro-centric, Western European	N	Y	Y	Y
	Primary Care Paramedicine	M	Euro-centric, Western European	N	Y	Y	Y
	Primary Care Paramedicine	M	Euro-centric, Western European	-	Y	Y	Y
LU	Collaborative BScN	F	Afro-Caribbean	Y	N	N	Y
	Collaborative BScN	F	Euro-centric, Eastern European	-	Y	N	Y
	Collaborative BScN	F	Euro-centric, Western European	N	Y	N	Y
	Collaborative BScN	M	Southeast Asian	-	Y	N	Y
	Collaborative BScN	NB	-	-	N	N	N
	Compressed BScN	M	Caribbean; Western European	Y	N	Y	Y
	Compressed BScN	F	Indigenous, First Nations	-	Y	N	Y
	Compressed BScN	F	East Asian	-	N	Y	Y
	Undergraduate Medicine	F	Euro-centric	-	N	Y	Y
	Undergraduate Medicine	F	Euro-centric	-	Y	Y	Y
	Undergraduate Medicine	F	Euro-centric, Western European	-	N	Y	Y
	Undergraduate Medicine	F	Indigenous, Métis; Euro-centric	-	Y	Y	Y
	Undergraduate Medicine	F	Indigenous, Métis	-	Y	Y	Y

Note. A breakdown of participants' reported backgrounds and identities.

Of particular relevance to students' identities and their involvement in working towards health equity as just and socially responsible providers was their involvement with the community. Students at Lakehead University appeared to be actively involved in their communities, reporting both current and previous voluntarism and community work, with 46% of participants reporting current volunteer work. Community involvement ranged from current endeavors: "I do a lot of volunteering at the Dew Drop Inn" (BSNCOM2); to previous voluntarism "I used to do quite a bit with the Special Olympics, and then again, coaching… younger ski kids" (UME3); to occasional, passive activism "well, I've signed lots of petitions" (BSNLU2). Participants highlighted causes that they were passionate or enthusiastic about such as "transgender healthcare" (UME2), "support(ing) the BIPOC community" (UME1), "women's health" and "Indigenous rights" (UME4), "Missing and Murdered Indigenous Women and Girls" (BSNCOM2), and "mentorship" (UME5).

Among Confederation College students, many mentioned previous volunteer work such as in "high school" or during their previous post-secondary programs (PCP4, PN2). Others mentioned how they felt they did not have enough time to volunteer, one student mentioned how they had been quite involved in various clubs and volunteer roles, but "need[ed] a break" (BSNCC2). Another two students mentioned having no time to volunteer or otherwise be more involved in the community: "school has kind of just taken over my life" (PCP1), "I do some volunteer work here and there too when I can. It's kind of tough with school" (PCP2). Voluntarism and community involvement ranged from "volunteer[ing] at the soup kitchen" (BSNCC1), "volunteer[ing] at the hospital" (BSNCC4), "volunteer firefighting and first response" (PCP2), to working with particular groups such as being a "coach" for youth sports (BSNCC1, BSNCC2), working with children (BSNCC3; PN3) "volunteer[ing] with orphans"

(BSNCC4), and "volunteer[ing] for practice labs and help[ing] out the first year [PCP students]" (PCP1).

Additionally, students elaborated on previous post-secondary education experiences. While only the UME program requires previous post-secondary education prior to enrollment, various students across both cases reported having enrolled in or completed additional post-secondary coursework. Students within the compressed BScN and UME programs (Lakehead University case) were those who reported prior post-secondary education. Of those, there was a mixture of biomedical and biological sciences backgrounds, public health backgrounds, social sciences backgrounds, and a combination of biological and social sciences. There were two students who reported also completing a graduate degree prior to pursuing their current program (both UME students). In total, 8 of the 13 students interviewed for this case had completed a previous post-secondary degree. From Confederation College, 7 students reported having prior formal education at the post-secondary level, the majority of which were science, technology, engineering or math (STEM) related. Of these students, 2 had completed undergraduate degrees in the biomedical sciences, 1 had a diploma in a social sciences discipline, 1 had an undergraduate degree in a STEM-related field, 3 had begun but not completed a bachelor's in the biomedical sciences or STEM-related fields, and the last student had reported having taken the pre-health program at the college prior to starting in their current program.

It is important to consider previous educational experiences and voluntarism as they relate to the findings of how students felt they had been prepared to work on SRSJ. As seen in Theme 1 (for both cases), personal background was seen to play a role in how students perceived their academic preparation– with previous education, occupational experience, and life experience all influencing this preparation.

In addition to personal identity and experiences, students were asked to elaborate on their conceptualization of "health equity" (i.e. what does the term mean and how can it be achieved? See Appendix J). Understanding how students conceptualize this is important as the premise of SRSJ is to work towards health equity. Thus, while the focus of this study is SRSJ and whether students feel prepared to enact it as future HCPs, it is important to know how those being taught SRSJ might connect this to health equity if at all.

Students from the CC case spoke of health equity as everyone having "the same quality of life" or "level of… health as everyone else" (BSNCC3); everyone "get[ting] the care that anyone else would" regardless of who you are (PCP4); and "putting everybody at the same level… in a way [that's]… actually achievable—that people want to go forth with it (PN1). To achieve health equity, it was felt by many that addressing access and barriers to healthcare was important. This was evidenced through mentions of being able to access care according to one's needs (PCP2); access to equitable care regardless of one's background (PCP2; BSNCC3; BSNCC2; PCP1); and even access to "safe" care as one student mentioned (PN2). Students also mentioned the need for more advocacy on behalf of the healthcare system to increase access to resources and how the government plays a role in that (PN3), and how they themselves might also play a role as an active voter, "voting a certain way" to influence policy (PN2).

From the LU case, students conceptualized health equity as being accessible healthcare for everyone (BSNCOM1; BSNCOM2; UME4); and care according to one's needs, using the common health equity versus health equality baseball game graphic (see: Nussbaum & Allen, 2022) (UME3; UME5). To achieve such outcomes, students spoke of needing to work on personal and societal biases and stigma (BSNLU1; UME4); working on up-stream and extra-clinical factors of health such as healthcare system structures (BSNLU5; UME1; UME4;

UME5), as well as SDOH and access to healthcare (BSNCOM1; BSNCOM2; MD3). In terms of upstream factors, students spoke at length about supporting funding and programming for minoritized and vulnerablized populations (BSNCOM2; UME4; UME5); and even increasing representation of minoritized and vulnerablized populations (BSNLU5). One student spoke of increasing collaboration as well between resources that are already in place “to cover the grey areas” for healthcare coverage and access (BSNLU2).

Alongside questions of the meaning of health equity, students were asked to elaborate on their perception of the roles and responsibilities of their future profession. Responses varied across the programs within each case. From the Confederation College case, students spoke of advocating for patients (BSNCC2; PCP2; PN2; PN3); providing quality care (PCP2; PN3); and being the face of healthcare (PCP4). While advocacy as a professional responsibility was reported, it was often reported by nursing students, whereas quality patient care and professionalism aspects were frequently reported by PCP students.

From the Lakehead University case, students spoke of roles and responsibilities being patient-centred care (BSNLU1; BSNLU2; UME1) inclusive of advocacy, both in and outside of the clinical environment (BSNCOM3; UME3); helping patients navigate the healthcare system (UME2); and listening to patients’ when it comes to their concerns surrounding their health (UME4; UME5). All of these responses to the meaning of health equity from students within each case help contextualize the themes that arise throughout the data. Coupled with students’ backgrounds and understandings of their professions’ responsibilities, the data across the themes may help to uncover gaps where curriculum, pedagogy and program planning may be addressed to improve student learning outcomes.

Themes

The themes have been organized by case and research question. To begin, students' opinions on their academic preparation to work as just and socially responsible providers are presented, followed by the various components that influenced those opinions. Refer to Appendixes P and Q for theme tables.

Lakehead University

Theme 1: Preparation is a patchwork

The majority of students at LU reported feeling prepared. However, a majority of students within this case qualified their preparation as being a result of having lived or working experience with such concepts in their life prior to their education. For example, one student said "I think it's personal training and personal life experiences… that I kind of bring into this, that prepare me" (UME4). Another mentioned how personal drive played a role: "if you weren't necessarily motivated to [work on these concepts]… the answer would be no… but for someone who is motivated, easy—it's an easy yes" (UME1). Many students also pointed to a combination of personal and academic experience that contributed to their preparation, with one reporting:

> I feel like the information and the approachability, and… my ability to collaborate with patients and stuff like that, that comes from my prior work experience, and isn't something that was gained in this program. I've just tried to take the concepts and learn and tried to understand them and advocate in my own way. (BSNLU2)

Another student felt that their "lived experience [had] given a lot more insight versus [their] academic experience [which] allowed for more reflection to kind of… realize some things" (BSNLU1). Another student reported not feeling influenced at all by their program's teachings (BSNCOM2).

Theme 2: The theory to practice gap

When discussing preparation, many students pointed to the gaps within the curriculum that may result in students missing the uptake of key concepts related to SRSJ, often seen as a lack of ability to apply theoretical concepts practically. This was especially evident within the distributed learning models:

> the more hands-on stuff really comes in like, third and fourth year… when [they] go away and those experiences vary from person to person… there's a lot more focus on health equity and… advocacy within the community. But… [for their] peers at a lot of other sites, that's not really an emphasis in the second two years of medical school. (UME2)

Despite reporting a valuable learning experience within their current placement, the same student noted that one of their placements had been less than fruitful—being placed in a predominantly Francophone community, making the application of such concepts "less navigable… because [they were] not that fluent in French" (UME2). The same idea was brought up by another student saying that the level of preparation given by their program to apply concepts "depends [on] what community you're in too" (UME4).

Additional gaps were seen, for example, one student mentioned how their program "did a decent job at… at least making [the students] aware of [SRSJ concepts]. But [they thought that] a lot of it falls onto [the students] to… learn how to utilize them" (BSNCOM1). This same student mentioned how in clinical placements, being able to apply SRSJ came down to the "clinical instructors and how some of them took the time to… have debriefs" noting that "some of them did a better job at that than others" (BSNCOM1). Another student echoed this stating that "so much of it is dependent on [the] clinical instructor and how willing they are to incorporate those

discussions", making them "hesitant to say [that their] academic training" had prepared them to work on these concepts in the future (BSNCOM3). A third student mentioned how topics related to SRSJ, while repeated often in every year (such as SDOH), may be brushed over according to the teaching style of the instructor and whether that instructor believes the concepts have already been covered (BSNLU4).

In terms of Indigenous health considerations within the curriculum, one participant brought up the notion that some international students may not be as familiar with Canada's colonial history: "I have peers who are international students that… have this idea that… Indigenous people are… weak and vulnerable", relating it to their program's perceived "lack… [of] nuance, and… context" with regards to its teaching on Indigenous health and SDOH (BSNCOM2)—something that was relayed by another student, who reported not fully discussing the depth of intersectionality and its role in health outcomes (UME4). Another student pointed to the structuring behind the first-year Indigenous cultural immersion placement that their program requires, pointing out the cracks that may contradict the use of SRSJ in practice. This student mentioned having "qualms about" the program's way of positioning this placement:

> … they set it up in a way that like gives students this expectation that they're going to have… a revelation of like 'wow, I know everything now and… I understand this whole culture and… I could never now be culturally insensitive'. (UME3)

Participants noted that such theory to practice gaps led to feelings of "learned helplessness" as one student termed it—feeling as though they were being taught about "all the problems [such as]… the impacts of social determinants of health without tangible solutions or ways to facilitate change to address them" so that they "feel outraged about… [it without having]

the capacity to actually enact change beyond [individual patient care]" (BSNCOM3). Other instances came about when students spoke of the theory learned in class not being applicable to the clinical experience for example when providing care to a patient who does not speak English: "in class we talk about 'let's go find a translator'… it's not realistic… it's kind of like everything that you learn in a lecture doesn't get applied in real life" (BSNLU3). Another student spoke about being unable to address SDOH such as food insecurity: "people can't afford food and …that leads to lots of problems… ideally, I would be able to connect these people with resources to get food. But I'm not in a situation to give… those resources" (BSNLU5). Other students echoed this sense of helplessness with one third-year student stating "I think it's… tough when we talk about like recognizing that there's health inequity, or we have… the skills or the discernment to be able to know that's inequitable, but no real skills in what to do with that" (UME2). Another third-year student spoke about how the advocacy taught in the classroom is "observatory, but [not]… actionable. It's like, this is what we see. We should do something about it. But… [it doesn't go] a step further" (UME4). This student followed up by saying:

> I think it would be very difficult to tell people step by step how to do [advocacy]… because that's not how that works, otherwise that would already be the system, but it is… something that is overly touted [by the program] for how much it's actually taught. (UME4)

Theme 3: (Un)supportive learning environment

Students generally pointed to a lack of support when reporting issues with their program or challenging its delivery, and to power dynamics that silenced them despite wanting to challenge the curriculum. One student who felt supported said that their "clinical instructor… validated [the students for bringing up an issue]… told [them] that it was abuse" that they had

witnessed and said they would talk to the floor manager, “but also really listened to [them] and made sure that… it was okay with [them]… he assured [them that he was going to keep it private, [and] that [they] did the right thing” (BSNCOM3). However, others noted feeling unsupported by their programs, citing instances of clinical instructors who “made people in [their clinical] group cry” (BSNCOM2), or relaying a sense that their program has “a very hostile environment of people being very anti-change and anti… anything good” (BSNLU2). This last student also noted a lack of support when challenging curriculum stating faculty

> would answer the question… but it would be very, very vague and… repetitive of what they had just stated earlier. It wouldn’t be an elaboration. And then they would say ‘is that clear?’ And then you would either have to say ‘no you still didn’t answer my question’ or you just say ‘I’ll just figure it out on my own’. (BSNLU2)

Another student reported how they were explicitly told by an instructor prior to starting clinical that “if you see things, don’t question it” within “the first two weeks” of starting their clinical rotation (BSNCOM3).

Further responses from participants illuminated the power dynamics that fail to support students within their programs in both the classroom and clinical settings. For instance, in the clinical settings, one student reported how “the power dynamic and the hierarchy… was made abundantly clear from day one [with]... the majority of nurses and PSWs on staff… [making it] very difficult to challenge and do something about” (BSNCOM3). They further noted how off-handed comments would be made and

> all of the nurses and PSWs around you are not shocked. And then it puts you in this weird position of ‘do I say something?’ It’s only my first day… like I want to say something

> but I also don't want to speak up in a way that makes people see me as difficult because I hear that term so much thrown around about patients and residents. (BSNCOM3)

Another student recollected how they had tried to challenge a clinical instructor when the instructor didn't believe a patient's pain:

> I would look at them and they're clearly in pain… or they would tell me they're in pain and I would go to my instructor and say, 'hey, can I get some pain meds for this person?' Sometimes they'd be like, 'well…' And I was like, aren't we supposed to always believe it when they're in pain? Isn't that the whole thing? Things like that where I'm just like that counteracts what we learn, but you're the pro… okay… (BSNLU5)

This student also recalled a time when a clinical instructor was incorrectly administering medication and when challenged by the student, "decided it would be a great time for [the student] to go and give [their] first injection to a patient" despite them being "visibly upset", noting that the patient "could tell that [the student was] freaked out to give [them] a shot" (BSNLU5).

The power dynamics between students and mentors continued to be mentioned with one student discussing their concerns about addressing behavior that contradicted SRSJ in their community placement: "I think… sometimes it's hard as a student when you don't know the preceptor to… know what to say… especially… [when you are] kind of… imposing for 3 hours" (UME1). Another student mentioned how "sometimes you have to sit back and watch things go horribly" in clinical settings as "you watch the person you're working with interact with a patient thinking I wouldn't [have]… said that but you don't say anything because you're just a student and that's how they're running their practice" (UME5). Other students pointed to their program not being supportive and holding power over their students, for example "the school is not

willing to, like, let students take time off if they need to… [attend extracurricular activities]. And will, like, deny people time off to attend external trainings, and things like that"—even if related to concepts such as SRSJ (UME4).

In addition to lack of support when challenging the curriculum, students reported instances of overt contradiction of SRSJ by instructors and staff within clinicals. Students mentioned: clinical instructors being discriminatory towards both patients and students (BSNCOM2). Further examples include a student witnessing clinical staff telling a patient "that if [they] continued to act out… that they would send [the patient] to the floor with COVID" (BSNCOM3), and one student discovering "a full-blown, necrotic foot wound with… at least an inch around of slough" on a "known transient [patient], who… was literally still lying there in the clothes that [they were] admitted in… [not being] offered a shower, anything... [and] nobody [having] looked at [their] feet" (BSNLU2). A more blatant example also came to light when a student noticed a medication was "extended release" yet "people [were] obviously crushing it. [So that the patient was] getting it wrong" and when they questioned it, "[the instructor said] that wasn't [their] problem" (BSNLU5).

Students also noted simply not seeing the concepts employed in practice. One student mentioned how care is "condition-focused", leaving concepts related to SRSJ to the wayside (BSNLU4). Another instance of a failure to exemplify these concepts arose when one student mentioned how in their most recent "rural… placement… there was a lot of… judgemental nurses… where it wasn't as… safe" continuing that while "there wasn't any abuse", they were concerned for their patients (BSNLU3). Another student mentioned how they saw these concepts being employed in clinic however "not to the… amount based on the importance it was given in the classes" (BSNLU5).

Two students mentioned that these concepts were not modeled by everyone, or the majority, within the clinical settings. For example, one student said:

> I think it comes down to that whole individual idea of equity. Some people, especially recent grads or those who, that is particularly near and dear to their heart. Yes. Like they will take that equitable approach… but like a lot won't and a lot won't really be, faulted, or kind of called out for… [that] as well. (UME4)

They continued to say how they found it "surprising… that [the program] wasn't choosing preceptors [who] integrated [SRSJ] into their practice" (UME4). The second student mentioned an instance where they were seeing a patient who was "feeling depressed… and… anxious all the time and that wasn't really further… discussed" during their prenatal appointment, noting that the "structural issues [related to this patient's social situation]… were kind of glossed over" (UME1).

Students also talked about how others adopted the non-SRSJ behaviours and mentalities gleaned from clinical staff. For example, one student mentioned how it was "very easy to get just stuck in the loop of whatever the nurses on the floor [were] doing" (BSNLU1). Another student gave an example of picking up the mentalities of clinical staff:

> when [a patient] doesn't want to do something [some nurses]… say 'oh this is a hospital, not a hotel'… [well] somebody I'm in school with said that… because [they] heard it from [some of the]… nurses, and now [they're] saying it too… that's how it happen[s]… it's that quick. (BSNCOM2)

The adoption of such mentalities and behaviours also coincided with feelings of burnout and lack of application of SRSJ among both students and HCPs in the clinical environments. One

student talked about their time in placement mentioning a patient who continuously rang their call light for the nursing station. The student said they felt it was “getting old” and that “in that moment… [they were] just kind of annoyed and frustrated, because it was… a long night” (BSNLU3). They continued to say that this patient had been seen by the staff as particularly difficult and requiring more attention and that the student found themselves “not really kind of considering maybe like why [the patient] was doing that. Just kind of assuming that she was just like frustrated” (BSNLU3). The student later regretted the lack of attention and care they provided as the patient “literally died a couple days later” (BSNLU3). Similar to the staff mentalities that this student was beginning to model, many students reported a lack of staff exhibiting SRSJ in conjunction with burnout. For example, one student touched on the burnout that staff were facing saying “although I recognize the impact of burnout… it does warp the way that you see things and [how] you react… I think… the majority of PSWs and nurses that we see… will make comments that, kind of [are shocking]” (BSNCOM3). Another student relayed how some workers do the work, but “others come across as negative… some people are just really burned out and… regardless of who the patient is or their background, they just treat them rudely and poorly” (UME5).

Further examples of how the healthcare staff or the clinical environment negatively impacted students’ uptake of SRSJ was also exemplified. For instance, students mentioned recent graduates being “jaded already” (BSNCOM2). Another student mentioned that the concepts of SRSJ did not appear to be exemplified by “a lot of the preceptors [who were]… graduates of [the] program” (UME4). They thought it was “surprising” given the emphasis of the curriculum on such concepts and that it seemed like "even… grads of the… program that were now preceptors had kind of already forgotten about [such concepts]” (UME4). The impact of “being

overworked" and how that spreads its "negative effects" to "team work, staff mentality, and… patient care" was also mentioned (BSNLU2).

Another main component of this theme was the idea that SRSJ are blatantly disregarded or contradicted when in non-patient-facing settings. Multiple students mentioned banter between workers in the clinical setting at times taking a discriminatory tone, such as in the break room (BSNCOM2). Another student said they did not notice the contradiction of these concepts in the direct care, "when they're standing beside the patient"... "but… in conversations, you notice it in how they're referring to their clientele" (BSNCOM1). Students also mentioned that such contradictions to the learned curriculum were acted out "in a passive way" (UME3). For example, this student mentioned the way in which certain patients might be "termed", the "interactions that are happening with the patients… or between providers about a certain patient" or even "overhearing a conversation" that did not exhibit SRSJ considerations (UME3). Another student mentioned that while they were in rural clinical placements "the staff are very rural and very White… [and it's] difficult to sit behind nursing desks or… ER desks and be trying to mind your own business… [when people are] just commenting about the patients and things like that" (UME4).

Lastly, within this theme was the idea that SRSJ are undervalued within the curriculum. For example, students talked about formal assessments having less of an emphasis on these concepts in comparison to more biomedical concepts:

> in third and fourth year… [they] have to get assessments on… different patient encounters… in clinic and in hospital… most of that is medical skills, but on each of them, there are things like 'considered the social context of the patient,' 'considered access to resources'… so there's a few points… around things like health inequity, and

> social determinants of health, but less so formally assessed in the second half [of the UME program]. (UME2)

Another student indicated that while it can be difficult to assess acquisition of SRSJ, having feedback on the more "hidden" components of the intended learning (e.g. working in a culturally safe and equitable manner) would be beneficial (UME4). Another student mentioned that "you're tested on [SRSJ-related concepts] so you have to know the information", but the concepts were not discussed much in the courses for which attendance was mandatory (UME1). Students also spoke of instances where concepts were undervalued within the curriculum. For example, a student mentioned how within their program, "some of [their] exam questions are based on the readings [from their community-based learning (CBL) sessions], which can include… outdated information and concepts so [they] are being quizzed and the correct answers are not necessarily true" (UME5). This is important to consider as the CBL sessions that this student refers to are those which focus heavily on SRSJ-related content (i.e. SDOH, BIPOC health, etc.). Finally, in terms of grading schemes, one student mentioned how their program's grading scheme was differentiated based on type of knowledge being assessed: "for theme 1-3, [and] 5 (public health, SDOH, clinical knowledge), you just have to get a cumulative 60% by the end of the year" noting that "this is a barrier because if you are worried about passing Theme 4 (sciences)… the other stuff gets dropped… It [is] unfortunate but sometimes when prioritizing [it] is the more social aspect that gets dropped" (UME5).

Theme 4: Contextualizing the curriculum to place and practice

Unique to the LU case is students' perception that there is an emphasis on contextualization of healthcare practice to northern Ontario. Students mentioned time in community for clinical placements, the use of community speakers and guest presenters, and

contextualized curriculum and experiences that all work towards preparing students for a career within the region. For example, certain programs have various community placements and even have the option to participate in a new stream "pertaining to Indigenous people's health and wellness" where they might go on a "retreat to someone's moose camp [and] talk a bit more about… Traditional Medicines" (UME1). Students are also required to participate in "community learning sessions" where they shadow various local HCPs "to understand and appreciate other professions more… to work inter-professional[ly] moving forward" (UME1). Furthermore, community engagement is integrated into the curriculum via a placement in first year in "a small First Nation community" (UME3), "two, one-month, rural community placements… [where] you stay for an entire month and you're doing mostly clinic work… and then in third year… [going] to a community for the full year" (UME2). Unique to the first-year placement in an Indigenous community in NWO is the idea of full immersion. As one student stated "you're immersed in the community… for four weeks… it's unlike clinical placement where on the weekends… you could leave… [with these placements] you're… immersed in the community… [and they]… basically build… your experience while you're there" (UME3).

The majority of BScN students reported community engagement, but not to the extent that they had hoped for. While students were engaged in clinical experiences as early as the first year of their program, many were heavily impacted by the COVID-19 pandemic. As one student stated: "we didn't get a full third year placement and… I feel like there was a second-year placement that we missed that had to be online… COVID really did a number on our education" (BSNLU3). Another student relayed how having clinical education requirements completed virtually "may have limited, or… impacted the way that [they] absorbed the material" (BSNCOM1). While some third-year UME students reported lacking their first-year community

placements due to the pandemic, they reported being back in community placements following the height of the pandemic (into their second year). In addition to the impacts of the pandemic, some students reported a lack of community engagement outside of clinicals, as one student stated, “I don’t think [the classes] have [community experiences] anyways” (BSNLU5). Even after the height of the pandemic, some students still felt the pandemic impacted their program. For example, BScN students talked at length about their desire to return to in-person community nursing placements, with one student relaying that the online nature of the community placement left them “disconnected”, a feeling they hoped to avoid when they chose to relocate to Thunder Bay for school (BSNCOM1). While the COVID-19 pandemic had impacts on both the UME and nursing programs at LU, BScN students reported not returning to normal in-person community engagements. In fact, one student reported feeling disappointed that other clinical placements and organizations had “opened up quite a bit… [but the nursing students are] still online” for their community placement (BSNCOM1). Despite the impact of COVID-19, there are other reasons behind students’ lack of community engagement. As one community-based BScN student relayed:

> I feel that so many of us want to work with [community] organizations… that there needs to be partnerships made and I just think that our program is in the infancy and we are absolutely not getting… the training that… would be helpful for us to be more culturally competent along with other things. (BSNLU2)

In addition to community placements, the use of guest speakers to contextualize the curriculum throughout the LU case was discussed at length. The most prominent takeaways were reusing particular guest speakers, the use of guest speakers to provide context via lived experience, and the need for more guest speakers. To the first point, the reusing of particular

guest speakers was discussed by students across the case. One student said that, “about a quarter of [the guest-speakers they] saw again…. in other courses [as] they were brought back to speak either on similar topics or maybe they went more in [depth]” (BSNCOM1). Another student relayed their disappointment as “the guest speakers were cool but [they] heard from the same guest speakers every single year… they did the exact same PowerPoint that they did the year before, this exact same person, exact same topic” (BSNCOM2). A third student relayed how some of “the formal lectures…did have guest speakers that were community members… especially from [one particular Indigenous community]” (UME1).

Students also mentioned the use of guest speakers for providing insight only afforded via lived experience (BSNCOM1). Some of the students’ experience with guest speakers who had lived experience was through “workshops… more outside of the formal curriculum… still put on by [their program] but like in… workshops” (UME2). Guest speakers were also brought in to talk about their work. A pharmacist for example was bought in “to talk about polypharmacy” (BSNLU2), a labour and delivery nurse to talk about their experience working “overseas” (BSNCOM2), and a “harm reduction [worker]” to discuss the importance of their work in the community (BSNLU5).

Some students expressed the need for change and revamping of the guest speakers who were being brought in. One student relayed a need for “more [cultural and ethnic] representation… through like guest speakers” however they noted that “otherwise… there are big steps taken” by their program (UME1). Other students brought up that guest speakers were not brought in to discuss concepts related to SRSJ, noting they “would have guest speakers sometimes… [but not] as much regarding like, cultural competence and… that kind of cultural safety, kind of aspect of nursing” (BSNLU3).

Within this theme of contextualizing the curriculum to place, students also mentioned instances of diversity in the classrooms, from diverse cultural backgrounds to lived and working experience among the students, that stimulated conversations and peer-teaching. One student mentioned that “at Lakehead the student population is quite diverse and there are a lot of people who [they] think would be willing to share their perspectives” (BSNCOM3). This was exemplified by another student who pointed to an instance in class where “a lot of students were sharing their experiences as immigrants…[and] not necessarily having the same access to healthcare as a permanent resident or citizen” stating “it was great to kind of reflect on that and… think about… what would happen if something serious happened and I didn’t have… health coverage” (BSNLU1). The student continued “I think when you have a lot of people… from diverse backgrounds, it kind of [opens] those dialogues that… might not be at the forefront of your mind (BSNLU1).

Students highlighted how the CBL sessions in their program were “student discussion” (UME1), “with a facilitator present, but… student-led, discussion-based” learning (UME2). One participant expanded on this, saying that the “discussion should be based off of the prior readings, and… the group… members’ experience” (UME3). They continued that there is

> quite a bit of lived experience, or… healthcare experience. [And] if they think it’s relevant, [the students] will kind of pipe up and… say ‘I can speak on this one’… but then other people might also choose to speak in questions that they feel like they either had experience with… previously working with patients, or might give example stories, or just like have some insight into that area... so… it is good in that way that people bring their prior knowledge to the group. (UME3)

Lastly within this theme was the idea of practical application of concepts as a way to contextualize and make the curriculum relevant. Being able to apply concepts related to SRSJ in their practice was a focus point within this study. As such, students responded to questions about whether they felt they could use these concepts in practice during clinical placements or in their personal lives. Students responded with a mix of answers, but most focused on how such practical application could be facilitated through debriefings, structured incorporation of reflection and reflexivity exercises, and having time to care for patients and clients in the clinical setting. One student underlined that debriefing was necessary:

> when you're in the middle of [clinicals]… you're not really relating it back to what you learned… it's important to reflect on what has happened… cause…if this is the status quo—if this is the way things are being done, it's easy to just get drawn into that. (BSNCOM1)

Another student mentioned that debriefs during clinical allowed them to "actually connect the dots in practice and then have a space where [they] can talk about [it and]… how [they] actually feel, [and]… how it's impacted [them]", noting one of their clinical instructors "did a very good job at discussing [the social determinants of health] at… every single one of [their post-conferences]" in addition to making the students think about these concepts for their care plans (BSNCOM3).

The second main finding with regards to applying concepts learned in class to the clinical setting was the importance of structured incorporation of reflection and reflexivity exercises. One student mentioned "in [their] care plans, there [was] a specific section on social determinants of health, and how they impact the resident or patient that [the students were] doing a care plan on" (BSNCOM3). This student also noted that self-evaluations were required in

clinicals with questions about how SRSJ concepts were applied to their work in placement. This had led to students going into "clinical thinking, 'okay…we actually need to focus on this'" (BSNCOM3). Another student mentioned that their "care plans and worksheets… [prompted them to consider] outside factors" such as SDOH while "also doing… self-reflection of how [they] were able to… use what [they] learned in clinical and how [they] were able to identify these factors" (BSNLU1). Two students referenced essay-writing as a way to talk about and practice advocacy. One stated, essays could touch on "what you might do as a practitioner to advocate if you were practicing in the community of or around the community of Grassy Narrows First Nation [with]… their mercury poisoning crisis" (UME4). Another student mentioned that they might be required to choose an issue and write to "a local paper to discuss why you're concerned about [the affected communities]" (UME1). Both of these examples involved engaging students in reflective application for practicing advocacy as future HCPs.

Last within this theme, is the idea that students needed time to be able to develop and hone their understanding of these concepts and then apply them in the clinical setting. This was particularly mentioned among BScN students who recognized that they had time to help hone these skills by having more time with patients—allowing them to apply SRSJ concepts in real-time, rather than simply reflecting on them. In one instance, a participant said "I just try… to give [patients]… time which I feel is something that… as a nursing student, I have, that many nurses don't… [so I] spend that time with them, talk to them, make the hospital seem… less… scary" (BSNCOM1). Additional examples of applying these concepts were given such as one student "pull[ing] out [her] phone… [to] look at resources" alongside their diabetic patient (BSNCOM2); another student sitting "with [their patient] and just let[ting them] talk… [just] listening to [them], and not interrupting [them]" regarding their run-ins with racism and their

lowered self-image (BSNCOM3); and another instance where "the length of the shift allowed [one student] to sit and have meals with [their patients], and… to learn about… what [patients] planned on doing after discharge… their social determinants of health and… their lifestyle outside [the hospital]" (BSNLU2).

Theme 5: Superficiality

The next theme for this case was the idea of programs "checking the boxes" in terms of curriculum they are required to teach. Within this was seen a tendency to adhere to the standards set out by professional and academic regulating bodies, often to the detriment of SRSJ-related concepts, and the inclusion of Indigenous-centred curriculum, often overemphasized. This led to feelings of superficiality and tokenism within the curriculum and the idea that the programs were simply ticking the boxes. Multiple students mentioned the idea of meeting the CNO and CANMEDS standards, with one student stating "I wish they would stop just checking the boxes" (BSNCOM2), and another stating that they "discuss those particular topics in a way to check them off because… of the school's mandate… [but] when it comes down to discussing… the nitty-gritty of it, we kind of just like talk about it to check it off" (UME4). When asked about whether the courses talked about certain concepts relating to SRSJ, students relayed that "they do in terms of… our CNO… entry to practice competencies" (BSNLU2) and that such concepts are "woven in through the… CNO competencies" (BSNCOM1). This same sentiment was expressed by UME students whose program "talk[s] about the CANMEDS roles extensively" (UME2) within the curriculum, particularly as it relates to advocacy, often getting "weaved into a lot of the conversation" (UME3). One UME student stated that while advocacy is brought up via the CANMEDS roles, "it's always very vague… it's not concrete, it's not structured, it's not instructional" (UME4).

Further examples of perceived superficiality within the curriculum were noted such as SRSJ-related topics being “briefer... than what [they] thought that they were going to be” (BSNLU2), or mentioning certain topics rarely, using them as “buzz words” (e.g. cultural safety, cultural competency and advocacy) (BSNLU4). One student relayed how when learning about anti-racism it felt as though one of their professor’s was “literally hitting… curriculum points… in [the] course outline that they had to hit to meet… the Indigenous learning objectives” (BSNCOM2). Students also noted that topics such as “intersectionality [had] been touched on but definitely not… to the depth that it should be addressed” (UME1), and separate from “its root from Black activist, late Kimberlé Crenshaw” noting that it was “kind of lost in it’s purpose here… [and being] used as a catch-all term” (UME4). Another specific example of such superficiality was given by a second-year student stating that a CBL session was “probably the only one out of our whole like two years that [was] actually just about racism” (UME1). They continued, saying it “was frustrating because I think you can integrate racism and social determinants of health in things like that but… racism deserves more than a two-hour session of discussion” (UME1).

Students also expressed disappointment with the lack of guidance to dive deeper into topics and the general pressure to get through curriculum quickly. One student noted that

> the case-based learning… can be… pushed a little bit more by facilitators… [such as encouraging] a little deeper dive into… privilege… and power dynamics and powers that [are held as HCPs because]… at the moment it is very much like doing those conversations… as dictated by… the learning objectives, but… some more encouragement by facilitators would have been more impactful. (UME2)

Another student mentioned that facilitators were minimally involved and not "providing much of their own input. They [were] facilitating the discussion" and overseeing that students were "touching on the topics that [they] sort of need to be" (UME3). Others mentioned the general mentality among students to skim over SRSJ-related concepts that had already been covered, instead of revisiting such topics for better understanding or more developed discussion of the concepts (e.g. discussing how racism and SDOH play into the outcomes for the case at hand versus a previous case that had been examined). For example, one student noted that some of their classmates "are more there to just kind of check off that box and get to the next topic, versus some… are more there to discuss it" (UME4). Another mentioned that while there was a lot of "open discussion" within the CBL sessions in the first year, these sessions became more of a chore as they progressed through their program, with students trying to "be efficient and hit the learning objectives and move [on]… because [they] have so many other things to do" (UME3). This line of thinking was also brought up in relation to what was testable or non-testable material with a student saying that although the material is important the "extra discussions are not testable or whatever and there's a lot of kind of 'let's just stick to what we have to know'" (UME2).

Many also noted that curriculum focusing on Indigenous health was generally very deficit-based. Students from across the LU case mentioned "Indigenous populations [being the]… highest yield in terms of these discussions" around SRSJ-related concepts (UME1), and that "Indigenous health… [was] very important… especially based on the location of the university, and the demographics here" (BSNCOM1). While some students recognized a justification behind such a heavy focus on Indigenous populations— "it's a pertinent kind of thing of life here" (BSNLU3), many students felt that the way such content was delivered could

have been altered. For example, one student mentioned “a lot of the material was repeated” and “leaned into more statistics” that were not always presented within the context of colonialism, with one of their courses for example touching on the statistic of “Indigenous adolescents… [being] at higher risk for… drowning,” presenting it in a way that “seemed as if it was because [of a]… lack of knowledge about swimming” (BSNCOM3). Another student mentioned an “overload of information which seem(ed) very token” as it related to Indigenous health and Indigenous populations (BSNCOM2). Additional comments were made regarding superficiality of the topic such as students desiring a “more in-depth seminar [rather] than [just] tick(ing) off ‘oh, we discussed Indigenous health’” (BSNCOM3).

Students also pointed out that along with the heavy focus on Indigenous populations, other “priority groups… [were] left out… [and] almost every single time that [they] talk[ed] about anything that’s related to racism, social determinants of health… [it felt] like it involved Indigenous people” (UME1). Other priority groups are discussed, but not thoroughly. One student spoke of examples of this such as a CBL session in which the “last question was about… health for Black individuals” out of a twenty-question discussion guide on racism in healthcare (UME1). This student mentioned how it seemed like the program “forgot that [Black populations] existed, but… remembered them because of… more of the recent events… especially starting in 2020. So [they] kind of threw it in… as a tokenistic kind of [gesture]” (UME1). Another student gave an example of other topics not being discussed such as “maternal mortality… within… women of colour … and you know, what is being done to really address that” (BSNLU1).

Theme 6: Front-loading of didactic material

In terms of the pedagogical style, students brought up the idea of repetition of key concepts throughout their programs as well as targeted front-loading[23] of theory prior to clinical experiences. For example, some students often talked about repetition of the SDOH: “right from the first year in the nursing program… there is a lot of repetition… where we hear the same terms, same concepts… come up over and over again” (BSNCOM1). Students talked about SDOH being a concept that is “pretty prominent throughout” the BScN program (BSNCOM2) and “continually mentioned in multiple classes” (BSNLU1). Students also mentioned revisiting other related themes such as “cultural humility, cultural competence…throughout many courses” (BSNLU3), “at least three or four” (BSNCOM3).

BScN students and UME students alike reported front-loading of curriculum related to SRSJ prior to clinical experiences. For example, one nursing student said that these concepts were “heavily dove into… and discussed throughout many courses. But, especially in the first year” (BSNLU3). However, while SRSJ concepts are discussed heavily in the first 3 years of the program, one student mentioned how this front-loaded curriculum is mostly, if not all, theoretical and hard to actualize as the curriculum does not necessarily provide practical applications (BSNLU4). Front-loading of theory also appeared to be used in the UME program, where students noted extra preparation in the first year leading up to their visit to a small Indigenous community (UME1), as well as “exploring things like cultural safety, cultural competency… anti-colonial approaches to health and healthcare… and intersectionality with different privileges” in the “first two years” of their program (UME2).

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[23] Front loading refers to “spending whatever time it takes to help students construct a foundation” of the theoretical concepts to be able to use them for further learning and, in this case, to apply in clinical settings and future practice (Smilkstein, 2011).

Despite the similarity in curriculum layout, some students reported that the main "delivery method for the more social-humanities concepts… is delivered in that small group setting… pretty much all discussion-based" (UME4), whereas other students reported their courses "were pretty much lecture" (BSNCOM2). While some made mention of discussion components, these were only discussed as happenstance and not built into the program standards, such as "people answer[ing] questions and, kind of spark[ing] discussions" (BSNLU3). While some students have designated "case-based learning which is more about social health kind of issues" (UME1), other students felt their program was "lecturing the crap out of [them and not] bring[ing] in a lot of… discussions, or guest speakers or anything" (BSNLU2).

Theme 7: Instructor identities influence learning

Students reported various characteristics surrounding the instructors within their programs, for example, perceived generational gaps between the students and some faculty, lived and working experience of the faculty, and having instructors from professions other than that of their program were reported alongside perceptions of how these factors influenced teaching styles and students' uptake of SRSJ concepts.

Multiple students mentioned a generational divide where older professors would perpetuate different ideas within their curriculum than younger instructors who tended to "partner" with students to assist in their understanding of SRSJ-related concepts (BSNCOM2, BSNCOM3). For example, one student mentioned that older faculty tended to "lean into didactic lecture styles—not as much discussion… [making] little comments, or steer[ing students] into… questioning, but not questioning too much… acknowledging there are problems, but not necessarily making a scene out of it in practice" (BSNCOM3). Contrastingly, this student relayed that younger instructors (most often PhD students or clinical instructors) tended to

provide more impactful learning experiences such as doing a "very good job at [debriefing]… at every single one of [their] post-conferences," attributing that to "[them] having graduated in the past few years" (BSNCOM3). It was also felt that those instructors who "are younger, doing their PhD… actually want[ed]… to help [students] become a good nurse" (BSNCOM3).

While the generational gap was noted by a few students, others pointed to a perceived lack of lived experience within the faculty to bolster learning of concepts related to SRSJ. For example, one student mentioned how "the instructors of the courses for the most part… were always very… motivated to teach that course… but [they] never saw direct connections in terms of… lived experiences" (BSNCOM1). While the "instructors can definitely convey the theory… as it's written in books… if they have that lived experience" they felt "that would also be important as well" (BSNCOM1). Another student recognized that "maybe it's hard to find people that meet the criteria that teach… these courses" (BSNCOM2). This thought was seconded by another student: "I think that we don't really have representation from… racialized groups that are not Indigenous within… the faculty, which I mean, is just also difficult when you do live in a place that has fewer Black or… other populations" (UME1).

Despite the lack of diversity within the faculties and perceived or actual lived experience, a few students mentioned working experience out in the community that instructors had. For example, one student mentioned how the instructors "are usually heavily experienced registered nurses… the majority of [which have] their Master's or… PhD… but they have a lot of experience, just floor nursing… like, hands-on experience seeing a lot of these kind of situations that could arise" (BSNLU3). Further mention of working experience was made: "there would occasionally be… Indigenous health, cultural safety-type things that were optional, that were taught by… Indigenous PhDs, or White PhDs that do a lot of Indigenous work, but nonetheless",

however these were not mandatory courses, meaning students may not have been exposed to these perspectives (UME4). One student elaborated on their desire for instructors with more lived experience, mentioning they wished "that the CBL teachers were able to be somebody that was knowledgeable on the topic… that [the program] did something like that in the first two years with [the] theme 1-3 discussions"—those which are focused on northern and rural health (theme 1), personal and professional aspects of medical practice (theme 2), and social and population health (theme 3) (UME5). They continued on to say that they did not mean that "there has to be an LGBTQ person teaching the LGBTQ session however somebody with a little bit more knowledge [would be appreciated] so… that the faculty would be able to facilitate the conversation a little bit better" when students are unsure of how to continue on with the discussion (UME5).

Lastly, multiple students mentioned that instructors facilitating CBL sessions were often not representatives of their future profession (e.g. physicians teaching UME or nurses teaching undergraduate nursing students). For example, one student mentioned how the facilitators change frequently and given the number of CBLs, there are "not enough people to specifically teach an individual CBL… [so facilitators are] more often people involved in public health, or within a certain discipline" however, they noted that "usually our topic oriented sessions (TOS) is about physiology and that is led by doctors" (UME5). Another student observed that they had never had "a physician [teach] one of the… humanities-type courses" additionally they mentioned that those who led the sessions were "allied health professionals [who] are kind of from the community. So for most of the case they're White and one who was Indigenous" (UME4). They further clarified that "[in the program], for the science discussion groups it's usually a physician and for the same day, right after, social science group, it's usually a non-physician, which [they

thought] was interesting" (UME4). Additional context was provided by another student when they mentioned that there's a range of different professionals who can facilitate these CBL sessions and that "they're often people who are just like leading that session, I would not say that the facilitators are specifically… facilitators who have a specific knowledge base or experience in that topic that are leading these sessions" (UME3).

Confederation College

Theme 1: Preparation is a patchwork

Within this case, most students reported feeling prepared by their academic program to work with people of diverse backgrounds. Only two students reported not feeling prepared themselves (one PN and one PCP student) and one BScN student mentioned feeling unsure whether they were prepared or unprepared by their education. Of those who reported feeling unprepared or unsure, the reasons cited were catching themselves "with… such heavy bias" when working with patients (BSNCC4), feeling like the students "understand the concept[s but]… it's all concepts in a textbook" (PCP3) and not understood outside of theory, and feeling like the program is "missing… classes, it's missing those aspects… [only having] three hours in a semester dedicated to abuse [for example]" (PN3).

Of those who felt prepared, there was recognition of how personal backgrounds and seeking of opportunities outside the academic program bolstered acquisition of concepts related to SRSJ. One student mentioned how "getting a job as a unit care aide and then working in emerge[ncy care]" helped them realize they "actually can do this and… have learned [from their program]" and was crucial in helping them feel prepared (BSNCC2). Another mentioned how the preparation from their program is "good enough", but noted that their "extensive background prior to [their] academic training" and the environment of "living in Thunder Bay… where… the

reserve is right in town… the systemic issues… are much more plain to see and there's much more knowledgeability… [regarding] Indigenous practices" (PN2). Another student said they

> came into [the program with such ideas and awareness], but [they] also [thought] Human Diversity (a mandatory course) did help with that understanding that… everyone has different circumstances and when you get to sit in an ambulance location for a very long time, [you] get to learn [a patient's] whole life story and kind of unpack what they went through if they want to talk about it. (PCP1)

One student felt as thought they had "learned a lot more" from being in the program, noting that they "think… there's more that can be done" still to promote acquisition of SRSJ (PN1). Two students noted how they felt prepared "other than language barriers" (BSNCC1), one of them mentioning how they felt especially prepared to work on SRSJ "in terms of Indigenous people" but "language barriers [can be]… hard to work around sometimes" (PCP4). Lastly, multiple students mentioned the idea of learning on the job and that they were "as prepared as [they] can be" (PCP1), and that "it's going to be learning on the fly. You're going to just hope that the program is recruiting, like good people, who like, ultimately want the best for the community" (PCP3).

Theme 2: Inherent (de)valuing of just and socially responsible care concepts

Within this case, students mentioned various experiences during their time in their programs that inadvertently contradicted curriculum on SRSJ, ultimately contributing to a hidden agenda of devaluing these concepts. Firstly, the undervaluing of SRSJ was reported by multiple students across the case and across programs. For example, one student mentioned how advocacy was "less present in [their] graded course work… it was touched on in the theory portion. But again, it… wasn't graded… it's definitely been discussed in [the] program, but it's

been less weighted than other topics" (PN2). Another student mentioned how concepts related to SRSJ "tend to be the exact questions that are… in the least amount [on exams]" before continuing on to say that they "get exam breakdowns. Something like… cultural advocacy is like one question" (BSNCC4). This same student went on to say that sometimes they "have essays, [however] this year's essays didn't really focus on [SRSJ]. It was more medical-based" before saying that they "always put that stuff [in their reflections]" despite it not being "even a part of the rubric" (BSNCC4). This lesser weighting of SRSJ in the course marks was brought up in relation to "case studies" that are used "not for marks or anything… [but as] more of a test [on student] knowledge" which leads to students "lots of times [not doing] it anyway" (BSNCC1). Multiple students mentioned how the one course that touches on these concepts is considered an "elective" (PCP2, PCP4), and that the grading scheme and expectations for elective courses is different from that of other core courses. "Whereas [students] need a 70% in any of [their] A-B classes, [they] need a 50% in [the human diversity course that touches on SRSJ]", there is an "expectation difference, between an elective and [the] core courses" (PCP4). Because of the lower benchmark for passing the course, the material is "not… a priority" for students within the program, and that "because it is like kind of an elective… on a daily basis in that class… 40 to 50% of [the] class was missing" (PCP4).

Students also reported various instances of not seeing SRSJ utilized in practice or being completely contradicted by providers in the clinical settings. Multiple students mentioned feeling as though they did not see these concepts being used outright. For example, one student said:

> I feel like I didn't see… anyone being racist or anything like that but I don't think anyone was really thinking about how this person like may be homeless, or this person might have had like some childhood trauma… I think they just kind of see the patient as they

> are and take care of them as they are. They're not thinking about where they're going to be after this" (BSNCC1). This same student continued to say that these things are not paid much attention as "in the grand scheme of things, it's not really our job. Like we don't decide where they go after. (BSNCC1)

Another student mentioned how they did feel that such concepts were used by other providers in the clinical setting but that "over time, [they might] become a little more… focused on like what's going on, like in the moment and not what else is going on" in the patients' lives (BSNCC2). A third student mentioned how these concepts were utilized at a "bare minimum… like they're not doing anything to… disrespect like equity and stuff like that, but they're not doing anything like to promote it" (BSNCC3). Another student relayed that they did not see any overt examples, such as "calling… housing for their patients because they're being discharged… or if they did, they didn't really like relay the information" to the students (PN1).

Students often spoke about not seeing SRSJ utilized in practice in tandem with providers being burnt out. For example, one student qualified the fact that they had not seen many displays of these concepts in the clinical setting by saying: "I'm sure lots of people… would like to go above and beyond but with the short staffing issues… it's hard for nurses to do those things cause they have to focus on the task at hand" (BSNCC1). Another student said "they might just be burnt out… it didn't feel like anyone was [avoiding these concepts in their care] on purpose. But it might have been missed like because they're under a lot of stress" (BSNCC2). One student even reported that they were already beginning to feel burnt out and adopting the behaviours of the other nursing staff:

> like [you have] your patient who can do anything and then your patient who really needs help with everything. It's like… I don't want to go in there. It's going to take so much of

> my time… it's just constantly pulling back and just saying 'but they need me'. (BSNCC4)

Further examples of the effects of burnout were seen such as how the emergency medical services (EMS) in Thunder Bay are "in a crisis… there's a lot of people—especially with the pandemic that are like, burnt out… And I think that kind of leads to a little bit of… patient care issues or questionable things getting done" (PCP2). Another student relayed how such burnout also leads to the more overt contradictions of SRSJ such as labeling of certain patient demographics and the use of certain derogatory terms to refer to equipment commonly used by EMS (PCP4).

Among the examples of overt contradictions of SRSJ, reports from students across the CC case were seen. For example, one BScN student mentioned how they will see "lots of incarcerated people and they're always treated last. It's like 'oh I don't want to go in there and have to take off a handcuff'" (referring to medical staff not wanting to engage with these patients) (BSNCC4). This same student spoke about an instance they witnessed where they

> watched a nurse go into a patient room, have a wonderful conversation about how scared [their patient was]… to go on Percocets, because they didn't want to be addicted. [Then] go into my patient's room and just say like 'well their brain's fried from coke use' in front of the patient. (BSNCC4)

This student also mentioned hearing "stereotypical… phrases… as soon as somebody that's Indigenous comes in… [with them being] automatically labeled as drug-seeking, or drunk. And their care… [being] immediately pushed away" (BSNCC4).

PCP students brought up similar examples where many overt displays of contradicting SRSJ are seen within their clinical placements. For example, one student mentioned how

“Indigenous people get a fair amount where we’ll have a patient and…. The 911 callers will just say that they’re ‘HBD’, “has been drinking’” without relaying further information about their acute status (PCP1). Another PCP student spoke to the use of derogatory terms to refer to equipment such as “bariatric straps [for the ambulance gurneys], or how some of the kind of burnt-out, long-term medics call them ‘fat straps’”, or even the “MegaMover [for moving people easily without a gurney], or again, what some people term it, ‘fat mat’” (PCP4). One student spoke to the lack of SRSJ that is seen from outside of their chosen profession as well in the clinical setting such as

> when you bring in a patient of a different ethnic background [to hospital and]… you’re trying to report that over and [the accepting providers] just write down that they’re been drinking and then, we’ll walk into the bed in 10 or 20 minutes and we’ll see that there’s nothing even attached to this patient that should have something attached. (PCP1)

PN students also spoke to these overt displays as well such as having “teachers where they make comments about drug-seeking, or they make comments about alcoholism such as: ‘well, you’re gonna think that they’re just drug-seeking and they probably are’” (PN3). A second PN student mentioned examples of immigrant patients seeking healthcare at the hospital and HCPs “mocking the accent and the broken English that they used”, and feeling as though HCPs have “almost found another group [to treat inequitably]” (PN2). Lastly, an important point made by a PN student was their observation that “graduates of the program at the hospital [are seen] saying those off-handed comments at a young age and a young year into their career”, indicating that the concepts of SRSJ have not been embodied by those individual graduates (PN2).

Theme 3: Contextualizing the curriculum to place

Within the idea of contextualizing the curriculum to the locale, students mentioned things such as incorporating guest speakers, discussing certain concepts such as Indigenous health and care considerations, as well as incorporating practical application of concepts into the curriculum. Multiple students talked about how curriculum was contextual to the area. For example, students spoke about discussing colonialism and the impact on Indigenous health within their classes, relating it back to how it's "very much so prevalent in Thunder Bay… [as] we're right on a reserve" (PCP4). Students mentioned how the curriculum regarding SRSJ was "related more to Thunder Bay" (PCP2) or talked about "generally and then… kind of like appl[ied to]… Thunder Bay" (BSNCC3). However, one student talked about how they felt there could be more done "to get [students] out of the school sooner rather than later" and to provide a better "connection to… what [they] were learning" (PCP3).

Additionally, students spoke about the incorporation of or lack thereof of guest speakers in their various courses. A trend was seen across the programs within this case where some programs were reported to have incorporation of guest speakers into the curriculum, and others to have a lack of guest speakers. For example, some students discussed having a guest presenter come in who "advocated for Indigenous rights and cultural things… in the hospital" (BSNCC1), guest speakers who came to facilitate an activity "called the blanket exercise" (BSNCC2), "public speakers… with lived experiences", "people from residential schools", and even "harm reduction" workers (BSNCC4). Other students either couldn't "remember specifically" if they had any guest speakers (PCP1) or stated that it "was always with… [their] teacher" lecturing on topics related to SRSJ (PCP4). One student mentioned they were disappointed by the lack of guest speakers saying "it's one thing to learn… what the residential school system was. But it's

totally different to hear it from someone who's, like, suffering from the consequences of that" (PCP3). Similar reports were seen by the PN students, with one student relaying that the program was "lacking in guest speakers" (PN2). One student mentioned that in addition to the lack of guest speakers, when it comes to Indigenous considerations for the curriculum, instructors "ask for permission from… Elders… to teach [their teachings] themselves… like they don't want other people teaching" (PN1).

Similar to the reports from the other case, the theme of having curriculum appear to be hyper-focused on Indigenous content arose here. One student mentioned how their Human Diversity course was "pretty heavy on the Indigenous population in northwestern Ontario specifically" (PCP1), while another student pointed to their classes being "focused on Indigenous health" but not talking "too much about… LGBT [health]" (BSNCC2). This second student continued on to say that while the main focus on Indigenous health "is a big help" they sometimes "found [themselves struggling]… when [their patients were] more of like a refugee family or something" for example (BSNCC2). When asking other students whether they felt like certain populations were focused on when it came to learning about SRSJ, one student commented:

> I mean you can put two and two together… through that diversity class we do talk a lot about the Indigenous population… so you can draw parallels… we don't actually like, directly talk about [the differences in health outcomes between Indigenous and non-Indigenous people and what it means]… you just kind of have to put pieces of the puzzle together. (PCP3)

Another student said that within their Human Diversity course, "Indigenous people [were] definitely like the second-most forethought of it" (PCP4).

Lastly, students reported either feeling supported or unsupported to utilize SRSJ as taught in the classroom within the clinical sphere. Students mentioned the use of mandatory reflection pieces, using simulation exercises, and debriefing with preceptors as helping them to feel prepared. Firstly, the use of mandatory reflective exercises was discussed by nursing students in both the BScN and PN programs. One student mentioned that they utilized the concepts in practice as they "know at the end of clinical [they] have to write an assignment… related to the social determinants of health and [their] client", noting that "the assignment did give… a good kind of connecting" of the concepts (BSNCC1). Another student mentioned something similar where they had "to write an evaluation for each clinical placement… [with] various points… to talk about how [they] advocate for [their] clients in different scenarios" (PN1). A second PN student however elaborated on this, explaining that they had seen a transition in the type of reflective pieces required during clinical placement:

> we had to do these log-and-learn activities where you could choose like an issue… concern, or just a situation that happened during your clinical time and write a reflective piece on it… but then in our most recent clinicals… they actually removed that weekly written assignment for something actually called smart goals, [that are only done] once in the clinical period… it's much less intensive, and I just found it was more generic… you just have to lay out two goals and reflect on them at the end of the clinical experience. (PN2)

They continued on to say how they "really missed the log-and-learn activity… because [they]… could discuss [issues] with [their] instructor… instead of like trying to find time to like discuss it with them… or remember it" (PN2).

Additionally, students mentioned the use of simulations to apply the concepts being learned in the classroom. For example, some students spoke about doing "scenario practices where sometimes it's just a communication scenario… with a death notification or a suicidal situation, or something like that. Where… it's high acuity and stress is high and everything else" (PCP2) Another student mentioned that these scenarios are done "as students together… and [they] come in blind and… do the job and hopefully… don't miss anything" (PCP1). Another student mentioned the use of simulation as well in one example where they had a scenario to discuss how to interact with "a patient who had a religious background" using "a mannequin [that]… talked" (BSNCC4).

Through the use of classroom simulations, as well as in the clinical settings, students talked extensively about instances of debriefing to recap on SRSJ or to relate them back to their practice. For example, one student relayed that they "had a really good clinical instructor" who prompted them to "actually reflect on [themselves] and then go in and talk [to their patient]" when they were feeling uncertain about how to provide safe care to a patient wanting to openly discuss their drug use while pregnant (BSNCC4). This student noted that they "didn't think [they] had much of a bias, but then… found [themselves] stepping back after [interacting with that patient the first time]… where [they were] like 'oh my god, how could you be a mother?' (BSNCC4). However, after their debriefing with their instructor, they mentioned how they had "such a good conversation" with the patient and learned much from the interaction (BSNCC4).

Some students mentioned they do "debriefs at the end of each… day" where the instructor "teaches [the students] to be more aware of what [they are] saying [and] how [they are] treating people" (PN3). Another student mentioned how one of their clinical instructors "actually discussed things… [giving the students] real life stories and… [asking them] how [they] felt

about stuff" noting that "it was really, really good, and [they wish] that [they] would have more time for that or like instructors would make more time for that" (PN1). Some reported having debriefs that often followed mock scenarios to "reflect on what [they] would've done" in comparison to how their peers handled the scenarios (PCP1). One student discussed how debriefs were also most often conducted following "ride outs, especially when there's… placement shifts [where]… with like very stressful, high acuity scenarios" (PCP2).

Theme 4: Superficiality

Across this case, the theme of superficiality arose. This was defined by instructors not elaborating on topics— "they kind of just, like mention things and sometimes they don't elaborate on it" (BSNCC2), or using topics related to SRSJ as buzz words: "sometimes it does just feel like a word or they're just kind of saying it" (BSNCC2). Other students mentioned this same sentiment, for example one PCP student explained that

> social determinants [of health] gets touched on very briefly… a bit of anti-racism, anti-colonialism does come up… [but] nothing in terms of cultural sensitivity or anything like that… [additionally] no real discussion actually happens between the professor and the students. So the concepts are discussed with [them] but there's no reflection. (PCP3)

This student continued on to say how SRSJ-related concepts "technically… come into [their] purview" but that they have not "reflected on how that relates to [them] representing [their future profession]" (PCP3).

Additional examples relating to superficiality were seen with students talking about instructors not providing examples or practical application. For example, one student discussed how when touching on cultural safety and cultural competency, the instructors will "say kind of like the textbook difference between them. But I feel like examples are important and especially

like, examples for… where we are, where we're doing placements and stuff" (BSNCC2). This same student said how when discussing legal implications for such topics and working in policy, instructors "kind of just mentioned that sometimes nurses will write to parliament and that's all they kind of really said", noting that there's no practical application of these concepts or practice in doing such activities (BSNCC2). This is important to note as some practical application was mentioned in terms of simulations with patients (within both the nursing and paramedicine programs) however in terms of advocacy, no practical application was seen by students.

Theme 5: Varied didactic styles, varied outcomes

Within this theme, students discussed having lecture-based versus discussion-based classes, having in-class activities related to SRSJ, and having these concepts blended into the curriculum versus frontloading of concepts in particular courses. Additionally, the impacts of the COVID-19 pandemic surfaced in students' reports across this case. A lack of engagement in SRSJ-related courses following the turn to a virtual model was seen (PCP2; PCP4). For example, one student noted how given the online nature of the SRSJ-related course, students would simply "sleep through" the class (PCP4). Feelings were mixed about the responses to the pandemic, with some relaying that Confederation College "did a good job changing things with COVID… [and] adapting" (BSNCC1), and others not "hav[ing] a lot of great things to say"—noting that this however was "not because of… the teachers or anything" but because of the pandemic and the necessary responses and changes to the curriculum delivery models (BSNCC3). Lastly, one student reported disappointment at clinical virtual clinical placement offerings and how missing out on such in-person clinical placements as their pediatric, obstetrics and mental health left them feeling severely underprepared going into their final year of school (BSNCC2).

In terms of the didactic styles utilized across the case, BScN and PCP students predominantly reported lecture-based format for classes touching on SRSJ. However, some PCP students mentioned a handful of opportunities for discussion within the course that touched on SRSJ (the class titled Human Diversity). For example, one student mentioned that discussion was used following a take-home exercise of watching a video on what life is like in Nunavut: “we had to watch it outside of the class, and then we came back and had an in-class discussion on it” (PCP4). Another student spoke of how their course on these concepts “was obviously not like discussions [based] with online class but… [the instructor] definitely opened the floor to [the students] a fair bit, and people… brought in their own ideas” (PCP2). Another student relayed that the instructor was “open to like questions and stuff” (PCP4). However, while these two reported having bits of discussion within their lecture-based class, another student reported that their section of this course was “your traditional like, PowerPoint presentation, didactic lecture. No real discussion actually [happened] between the prof[essor] and the students. So the concepts [were] discussed… but there [was] no reflection”, later continuing on to say “that was why a lot of people stopped going to the class. Because [they] were just there to listen to her speak” (PCP3).

The next component discussed in relation to this theme was the use of in-class activities to talk about SRSJ. One student mentioned how “there was… an in-class assignment every week [where they] used… some critical thinking… [and] kind of had to think about [SRSJ]… and… relate it back to like, other stuff from… the lectures” (PCP4). Further examples of activities include an online module aimed at “figuring out if you have biases” (PCP2) and use of “the blanket exercise” that was talked about by collaborative BScN students within the other case (BSNCC2). They mentioned how this exercise discusses “colonization and everything, and…

they kind of just go straight into the deep dive of it and it's really good and impactful" (BSNCC2).

The last component discussed within this theme was the blending of SRSJ into the programs' various courses or frontloading of the concepts in the first half of the programs. One student discussed blending of these concepts into the curriculum through courses such as "a mental health class" a "public health class" and "nursing theory courses [which] cover a lot of that as well" (BSNCC3). Another student mentioned how concepts related to SRSJ are not really discussed "too much in other classes, probably a little bit in [their] communications [class]" but otherwise solely in their Human Diversity course (PCP2). Unlike the BScN students, PCP students discussed having been exposed to these concepts through one sole "mandatory elective that all paramedics have to take… in first semester" regarding human diversity (PCP2), another student saying "the program is very front loaded with theory" and not much application of these concepts, also noting that the course appeared to be a "sociology course that… everyone goes through" (PCP3). When asked whether they had been exposed to various concepts related to SRSJ, they responded: "I think only Diversity would have been any of that"—referring to the Human Diversity course required in the first semester of the 2-year PCP program (PCP4).

Theme 6: Instructor identities influence learning

Much like the other case, the Confederation College case had reports of instructors in various settings across the programs influencing learning, both in positive and negative ways. Similar to the university case, students mentioned a generational divide between instructors' ages and the ideas that they disseminated to students and the benefits of instructors having work experience in the fields they teach in. Firstly, some students spoke to the generational divide seen within the faculty and staff. In the clinical setting, this was defined by the "older, the veteran

nurses, very much [being] stuck in their ways… lik[ing] the way things are", not promoting change or embracing new concepts related to SRSJ (PN3). Another student hinted at "the differences between the new generation coming in, versus the old" relaying that they recognized "a divide of care that [older nurses] have for [their] patient. If [their] patient doesn't look like [them], they're getting different care" (BSNCC2). On the other hand, students spoke about the benefits of a youthful perspective that some instructors had: "each week we can expect to discuss some sort of topic on health equity… and I think that can be attributed to again, the younger program coordinator really wanting to bring in everything… the CNO has to see" (PN2). This same student mentioned how the biggest differences they noticed in terms of identities that influenced curricular dissemination was the instructors' ages: "we kind of saw a stark contrast… with the age of the instructor… presenting the course material, there came a very stark difference in how the material was being presented" (PN2). The generational divide was plainly seen when this student relayed that:

> there was one individual that we had as an instructor… it was very difficult to not see the blatant bias they brought into teaching these concepts. And then we had another individual who was younger, actively working at the hospital, actively like putting these things into their practice every day, also teach similar content, they taught the follow-up course… it was much better received. (PN2)

Students also talked about the working experience that instructors brought in with them and how this aided their teaching and the applicability of such concepts to students' future careers. For example, students in the nursing program all had current nurses teaching their courses, one student noting "they worked in the hospital [in Thunder Bay]" (BSNCC1). Another student relayed how for their "public health class last year [the instructor] was… a community

nurse… worked for the college, and [was also] involved in a lot of… Indigenous-centred organizations… so she was able to… share a lot" (BSNCC3). This same student continued, stating that they had elected to take the majority of their courses at the college as "the teachers at the college, always [seemed to] be a little… better at… explaining that kind of stuff… they have more… interest in [SRSJ] and… [are] more passionate towards… like that kind of care" (BSNCC3). One PCP student mentioned how one of their instructors was "very passionate about [SRSJ-related topics]… and you could tell that these were issues that she care about" noting that they felt "lucky in this program [as]… a lot of the teachers… teach in the field that they work in" making the program content much more relevant and engaging (PCP1).

While these students relayed their positive experiences, other students mentioned how they only "had one [instructor]… [that] was actively doing that" (referring to working on these areas in their professional practice), later stating that other instructors appeared to have the mentality of "you have to teach [these concepts], so you teach it. And then you go home, and that's kind of it" (BSNCC4). One student also mentioned instances of the instructors not having any experience within the future profession of the students, stating "I don't know too much about [the instructor]… they have… a master's in sociology… no experience in healthcare. So she had no real way of connecting medicine with her teachings and like what it means in the greater picture" (PCP3).

Discussion

To discuss the findings of this study, I return to the overarching research question: do health professions students feel that their education has adequately informed, prepared, and encouraged them to work as a just and socially responsible HCP? Firstly, this question will be addressed before moving into how the findings align with current practices surrounding health

professions education today (i.e. frameworks for SA, health equity, and teaching advocacy to HCPs).

Firstly, to inform the discussion of the findings, it is important to revisit the students' positionings and understandings of the concepts being investigated, as well as to discuss the context within which the students are embedded.[24] At the beginning of the findings was listed student responses to a prompt regarding their conceptualization of health equity. Responses to this prompt from CC students revealed that many students conceptualized health equity as achieving a sense of health equality so that all receive the same care, same resources, and essentially can achieve the same level of health. This egalitarian approach to health was most commonly seen amongst participants across the CC case, but also shared by a few within the LU case. When asked how this might be achieved, participants from the CC case indicated that more systemic barriers needed to be addressed such that access to services could be gained. When asked what they considered to be their professional roles and responsibilities their responses indicated that they felt responsible to work towards such access given mentions of patient advocacy, quality care, and professionalism.

As for the LU case, students conceptualized health equity as everyone having access to healthcare as well as having care according to one's needs. To achieve this, students felt that working on upstream factors such as SDOH as well as structural factors such as policy, stigma and biases within the healthcare system would all help contribute to the goal of health equity. Unlike the CC case, there was less of a focus on equality, and more on equity and the nuances

[24] Understanding the students' backgrounds, as well as their constructions of the underpinnings of the research is important as social constructivism posits both the researcher and researched as engaged in the construction of meaning regarding the questions under investigation (Guba & Lincoln, 1994).

that such work requires. In terms of what students envisioned to be their future professional roles and responsibilities, the main focus across the students was patient-centred care.

Responses to these questions are important when considering the following discussion of whether students felt informed, prepared and encouraged to work towards health equity via SRSJ. Understanding the students' perceptions of what health equity means as well as how they envision their role as a future HCP is vital as it helps to understand why certain phenomena may be revealed through the students' responses. For example, students who respond that patient advocacy is key to achieving health equity may be focused on learning how to do this in practice and if such work is not seen in practice (i.e. in clinical settings), this may lead students to believe that such work is *not* being done by their programs and/or their professions—such results may lead to negative perceptions of their programs and the cases that house them. However, what is not directly seen across or within these responses is the context that work environments and the COVID-19 pandemic contributed to negative clinical and academic experiences (see: Employment and Social Development Canada, 2023; Statistics Canada, 2020). Thus, the structural components of the experiences shared within this such as HCP burnout (Maunder et al., 2021) and the student dissatisfaction created due to the transition to online education and delayed clinical rotations (due to COVID-19) need to be considered when analyzing the findings contained herein (Employment and Social Development Canada, 2023). Structural components such as decreases in supports for healthcare and higher education have significantly influenced the way that education has been delivered as well as the outcomes of such education both in classroom (or via Zoom as it were) and in the clinical settings [25] —as such there is much to be considered here.

[25] Grech (2021) found that the clinical educational environment influences the uptake of concepts and that burdened clinical settings which face understaffing and burnout contribute to negative effects on students' learning.

Given the context in which these responses are garnered, as well as the very nature of this social constructivist research, it is important to understand that findings are not binary. There is no one true reality for all students—all experiences are contextualized to the individual participant and many factors contribute to what that experience may result in. As such, the findings discussed herein reside in a grey area where there is no objective fact but subjective reality of what students have experienced. Here, I also want to reiterate that this study is not a program evaluation; Rather it is a snapshot in time of how students across these cases and in these particular programs are perceiving their educational preparation at this time in their education and in the contexts existing at the time of the interview or the time of the experiences/perceptions they refer to.

Do Students Feel Informed?

The findings reflected that many students felt informed by their programs on various topics related to SRSJ (e.g. social determinants of health, cultural competency, Indigenous health). However, despite generally feeling informed, there were certain concepts that students pointed to as lacking within the curriculum. Most often, these concepts related to certain marginalized groups such as “LGBT[Q]…health” (BSNCC2), “Black health” (UME1), and “immigrant health” (PN2). This is not new. Verbree et al. (2023) investigated UME students’ preparedness to work with ethnically diverse populations upon graduating where they found that students felt underprepared. Students in this study also pointed to a need to include diversity in the way of ethnicity, ability, sexuality and gender considerations within medical care (Verbree et al., 2023). Others have pointed to the need to expand on these concepts within education as well such as sexuality and gender minority (SGM) health (Burcheri et al., 2023; Luctkar-Flude et al., 2021, 2022; Ussher et al., 2021) and the health of people with disabilities (PWD) (Doebrich et

al., 2020; Morelli et al., 2023). In their paper, Stanley et al. (2014) similarly found that American nursing baccalaureate students felt under-prepared to work with diverse populations and concluded that programs require more and different types of education to instill cultural diversity awareness and social justice concepts within these students, something that is also advocated for in another paper assessing American nursing education surrounding SDOH (Thornton & Persaud, 2018). As for PCP students, little work has been done in this area within the Canadian context. O'Meara et al. (2014) discuss the expanding role of PCPs into community paramedicine[26] and how current Ontario PCP education models are not comprehensive in the way of concepts such as SDOH, public health, and CS. This is important to consider given the movement seen in Canada and globally of expanding community paramedicine models and in turn, expanding education models (i.e. transitioning from vocational and college-based training to undergraduate degrees for PCPs) (O'Meara et al., 2014).

It is important to consider what role student's reported identities play when discussing their desire to include more diversity curriculum focusing on particular demographic groups. Students who identified as members of a particular marginalized group often indicated that that group was left out of curriculum or not covered enough within the curriculum. For example, students who identified as being Indigenous were often critical of the way in which Indigenous curriculum was approached by their program or by the academic institution. Similarly, a student who identified as having a disability spoke at length about the need to include more disability-

[26] "Community Paramedicine is a model of care whereby paramedics apply their training and skills in "non-traditional" community-based environments, often outside the usual emergency response and transportation model. The community paramedic practices within an "expanded scope", which includes the application of specialized skills and protocols beyond the base paramedic training. The community paramedic engages in an "expanded role" working in non-traditional roles using existing skills" (as referenced by: O'Meara et al., 2014).

related curriculum and health considerations. While these students were often critical of the amount of curriculum dedicated to the health of people who are marginalized, other students who did not outrightly identify as belonging to a population who is marginalized, were less likely to focus on such gaps in the curriculum. This difference may relate to the silencing of certain non-dominant perspectives in academia. This point is raised by bell hooks in *Teaching to transgress* – one of the classics in Critical Pedagogy. One of hooks's main points is that pedagogy needs to confront and reconcile the differences between students and instructors in terms of their different backgrounds (i.e. race, class, gender). This should be done in an attempt to call attention to certain voices within the classroom, reconciling the power dynamics there and highlighting the importance of lived experience when teaching and learning. As Koster elaborates, "hooks essentializes experience and makes it the condition of authentic knowledge. Critical pedagogy comes to be about celebrating "the value and uniqueness of each voice" (84)" (Koster, n.d.). Thus, if programs are engaged in critical or transformative pedagogical methods to instill SRSJ among students, then the curriculum should reflect a multiplicity of voices. While this may be done by using resources and literature from various BIPOC scholars and clinicians to instruct students, this was not evident in students' responses—in fact one student relayed being told about concepts but that they were separated from their roots (e.g. learning about the term intersectionality but separate from its originally intended meaning; see: *Theme 5: Superficiality*). Ensuring that students feel represented within the classroom and curriculum by opening space for all students to discuss and reflect on pedagogy is crucial, but also ensuring that representation of various backgrounds and intersectional perspectives are present within the curriculum and programs is also important (hooks, 1994). Such representation can serve to bolster learning outcomes and engage students in their curriculum (Holihan, 2022). Lastly, as a consideration to

this point, while certain resources may be used to elaborate on theories and SRSJ-related topics (e.g. CS, intersectionality, etc.), ensuring that students are aware of the origin and original intent of the concepts may be beneficial. It may help students to more fully understand the importance of the concepts and afford a "solid grounding in theory" to later apply this in practice (Wrenn & Wrenn, 2009, p. 263).

Aside from a desire for more 'diversity curriculum', students most frequently cited a need for more information on how to enact advocacy type work. This was especially the case for nursing students across both cases who relayed that advocacy is taught as something that can range outside of the bedside care realm, but that was often not elaborated on within the curriculum. This lack of elaboration by instructors and programs may be due to the vagueness of the CASN accreditation requirements for BScN programs (see: CASN, 2014, 2020) and has been seen within American nursing education as well as purported by a group of nursing faculty in 2014 (Peltzer et al., 2014). The lack of literature exploring BScN programs attempts at instructing on such types of advocacy also supports the finding that there is much work to be done in developing this area of nursing curriculum. In relation to UME students in Canada such findings are similarly reported by Benrimoh et al. (2016) who note a need for more tangible advocacy-related curriculum that extends beyond the clinical setting, as well as educational frameworks to help guide programs to provide such teachings. Such concepts of advocacy are also not heavily focused on as per PCP students' reports either—with these students only discussing the idea in terms of advocating for patients during transfer of care to hospital staff. Again, this may also be due to the lack of direction for PCP education programs as seen in the paramedicine competencies outlined by the PAC as well as the current education system's

unseen attempts to adapt to the expanding scope of PCPs in Ontario (O'Meara et al., 2014) (see: Paramedic Association of Canada, 2011).

Interestingly, while students generally reported feeling very familiar with concepts such as SDOH, Indigenous health and various forms of cultural competency, safety, or humility, students who mentioned such familiarity are those in programs that have these concepts incorporated throughout the duration of their studies (rather than single courses). Whereas BScN, UME, and PN students most frequently reported a familiarity with SRSJ concepts, those in the PCP program less often reported such familiarity. It should be noted that all of the PCP students in this study had reported some form of previous post-secondary education (refer to Table 5). Three of the four students had some form of biomedical education prior to their admission to the PCP program, all of them reported actively or in the recent past volunteering, and only one of these students felt unprepared by the program to work with the diverse patient population of NWO. This is important as PCP students are only required to take one course titled *Human Diversity* in which the topics of interest to this study are explicit components of the curriculum. Yet despite the lack of reiteration of SRSJ concepts across the length of the PCP program, the majority of students interviewed felt prepared to work with a diverse population– hinting at the possible role of their personal background in helping to prepare them. However, as in Burcheri and colleagues' 2023 study, the correlation between Canadian medical students' increased exposure to concepts such as CS and CC oftentimes related to decreased confidence in their perceived ability to provide culturally competent or safe care (Bucheri et al., 2023). Similarly, in a study examining community college-level health professions students engaging in intercultural competency training, Hyett et al, (2018) found that students had decreased levels of cultural competency following completion of their course despite increased cultural knowledge. This

may be due to what Hyett et al. (2018) argues is an increased level of cultural humility, seen as an understanding that one knows in fact very little about another's culture. This may make students more critical of their ability to provide effective and safe care– something that other students such as the UME, BScN and PN students reported (i.e. not feeling fully prepared or confident in their ability to provide the most socially responsible and just care upon graduating). In addition to the possible role of personal background in academic preparation, there is a pedagogical difference across the programs. Whereas PCP students take one SRSJ-related course, UME, BScN and PN students reported taking multiple across the length of their programs. Such differences in approaches to pedagogy and dissemination of SRSJ-related concepts is also seen across health professions programs within the literature (for example, Dogra et al., 2009 and Forsyth et al., 2019a). While Forsyth et al. (2019a) explores the implementation of Indigenous-specific content and CS teachings among dentistry students in Australia, academics within that study report the need for earlier and more longitudinal implementation of such concepts to create a more culturally safe and socially aware HCP upon graduation. Similarly, Dogra et al. (2009) examine the current landscape of cultural diversity within UME programs across the United Kingdom, United States and Canada. What they found was that there were gaps between the implementation and outcomes across UME faculties within Canada (pointing to different pedagogical approaches for disseminating this SRSJ-related concept) (Dogra et al., 2009). While some time has passed since this last study, Beavis et al. (2015), further concluded that earlier and more longitudinal implementation of cultural diversity type curriculum (in this study Indigenous-specific curriculum and CS considerations) is required to prepare health professions students to work within Canada.

It is important to consider that such differences in pedagogy as seen across the programs may relate to programmatic structures (e.g. limited timeframe for two year programs or congestion of programs). Such timeframe concerns have been reported on in various papers analyzing the inclusion of SRSJ related curriculum across the health professions (e.g. in dental education: Forsyth et al., 2019a; in paramedicine: O'Meara et al., 2014; and across Ontario health professions education: Shah & Reeves, 2015). Additional contributing factors may include the lack of guiding educational standards as Benrimoh et al. (2016), Brender et al. (2021), Howell et al. (2019) and Li et al. (2021) purport for UME advocacy curriculum and Dogra et al. (2009) for UME diversity training, or a lack of prioritization of such concepts in the programs (Dogra et al., 2009). A more distal consideration but which implicates the cases is the repeated cuts to funding for Ontario postsecondary institutions under the current provincial government (Canadian Association of University Teachers, 2021; Canadian Federation of Students, n.d.). Ontario received the least provincial funding for postsecondary education, and with funding being cut and enrolment being expected to continually go up each year, institutions and students bear the brunt of the burden with increased class sizes, cuts to program options and resources and capped student grant amounts (Canadian Association of University Teachers, 2021; Canadian Federation of Students, n.d.).

Lastly, students who expressed positive experiences with learning of such concepts often also reported having instructors who were passionate about the topics they instructed, had lived experience, or who had working experience in the field in which they teach. This was also noted as important in a published conference presentation of students' experiences with anti-racism in UME, particularly that such instructors and faculty could help stimulate students' interest in promoting anti-racist praxis (Hariharan et al., 2022). This point reiterates the findings of master's

thesis completed by Regnery in 2021 regarding instructor identity and curriculum development. Findings from this phenomenological study interviewing environmental educators in California, included that the various intersections of an instructor's identity influenced the way that their curriculum was developed and the appreciation they had for the content they were disseminating (in this case, curriculum related to the environment). Another consideration here is that which representation in postsecondary education lends to the power dynamics of the classroom. As hooks writes (again in *Teaching to Transgress: Education as the Practice of Freedom)*, too often the classroom is stifled by power dynamics inherent to the differing backgrounds of faculty and students (e.g. faculty typically being of higher socioeconomic status and having more privileges, and students who may be of working class background or having various intersectional identities that compound to disenfranchise them) (hooks, 1994). Due to this, "bourgeois class biases [shape] and [inform] pedagogical process (as well as social etiquette) in the classroom... [and] silence and obedience to authority [are] most rewarded" however she continues that "bourgeois values in the classroom create a barrier, blocking the possibility of confrontation and conflict, warding off dissent. Students are often silenced when they have to accept the 'taught' class value that order must be maintained "at all costs" which again limits critical and transformational learning (hooks, 1994). Thus, it is important to consider what diverse faculty representation might lend to critical pedagogy and learning of SRSJ for health professions students. It appears that currently students from some backgrounds feel represented within the faculty and may feel freedom to voice their opinions in the classroom, whereas others may not.

Do Students Feel Prepared?

While students in general reported feeling *informed* on concepts and understanding the ideas of advocacy and health equity, they pointed to a lack of preparedness to work on these

concepts as future professionals, sometimes alluding to a feeling of "learned helplessness" as one student framed it (BSNCOM3). In a study looking at development of an advocacy curriculum for Canadian UME students, Benrimoh et al. (2016) relays the need for guidance on preparing UME students to enact SRSJ (in this case specifically, advocacy) in a system that has traditionally instilled learned helplessness. While this is specific to UME, it is unsurprising that similar findings were seen within the present study across all programs as these other programs have less guidance in terms of incorporating SRSJ per their educational standards and accreditation guidelines (Morris et al., 2019; O'Meara et al., 2014). This also relates to the previously mentioned findings seen within the literature that students with more cultural knowledge may report decreased levels of preparedness to enact that knowledge (Bucheri et al., 2023; Gray et al., 2020).

When asked whether they felt their program had adequately prepared them to work with people of diverse backgrounds (including but not limited to those of different ethnicities, cultures, genders, abilities, religions, etc.) students generally reported feeling prepared (10 of the 11 from Confederation College and 11 of the 13 from Lakehead University). However, throughout the length of the interviews, many students pointed to a combination of personal and professional background that contributed to their preparation to provide just and socially responsible care. Students who reported feeling prepared to utilize SRSJ in practice were most frequently those with prior post-secondary education, whether completed or otherwise. This is evident across both cases, and is not heavily supported within the literature evaluating this area of study, which often focuses solely on participants' experiences in their current programs, rather than the interplay of personal background and learning within health professions education. Only one study by Makanjee et al. (2023) assessing diagnostic radiology students' perception of CS

and CC, discusses the interplay of personal background and lived experience as influencing the acquisition of these concepts and ability to confidently and comfortably use them in practice. Within the Confederation College case, students with prior post-secondary education reported not feeling as though their individual programs were preparing students to work towards health equity as just and socially responsible providers. Across both cases, students who were more critical of their academic programs were also more likely to report feeling as though the programs were inadequately preparing students in this regard (whether it be themselves or their peers). At this point, it is plausible to consider the backgrounds of the group of participants garnered and how this may have played into the criticality seen among responses regarding programs' abilities to prepare students. Within this study, students who were more critical of their programs were those who had previous academic and occupational experience with such concepts (e.g. a Social Worker; and those with work experience in an under-served community), or lived experience as a member of a marginalized group (e.g. self-identifying as Indigenous or neurodivergent). Again, this may relate to the aforementioned findings from the literature review that increased cultural knowledge may result in a decreased perception of one's cultural competency as purported by Bucheri et al. (2023) and Gray et al. (2020). As Verbree et al. (2023) noted within their study looking at diversity and inclusion curriculum within a Dutch UME program, students who chose to participate were those who reported a desire to further such work—these same students reporting that the program itself was failing to prepare students to work with diverse patient populations.

Findings from the Confederation College case of students feeling poorly versed in advocacy work, working around language barriers and lack of exposure to SRSJ concepts is also supported throughout the literature. For example, in Yin et al. (2022), UME students in the

United States reported difficulty navigating language barriers in patient interactions. Students reported providing differentiated care to patients with language barriers, citing lack of time, lack of access to quality interpretive services, technical difficulties, cultural differences and difficulty establishing trust (Yin et al., 2022). In regard to not having advocacy incorporated in the health profession programs Morris et al. (2019) had similar findings as seen here. Following this discovery, Morris and colleagues (2019) implemented a 12-week graduate advocacy course aimed at Canadian Public Health students and noted that such education is applicable and necessary within other health professions programs, specifically mentioning nursing.

At Lakehead University students noted that instructors skipped over concepts that instructors believed were covered in other courses (instead of building on previous knowledge); instructors missing opportunities for debriefing in clinical environments; focusing on deficits-based curriculum for Indigenous health courses; and specific to the UME program, utilizing a distributed learning model that was perceived to limit or fail to support students' uptake of concepts relevant to SRSJ. Findings of a lack of depth regarding SRSJ-related concepts and missed opportunities for providing such depth may be attributed to a lack of prioritization of SRSJ across the case as is reported in the literature regarding UME (Dogra et al., 2009). However, such findings may also be due to structural issues mentioned before such as a decreases to postsecondary funding which causes trickle-down effects such as increased class sizes, and decreased course offerings (Canadian Federation of Students, n.d.), both of which could inhibit a program's ability to focus heavily on particular concepts due to time and budgetary constraints. In addition to a lack of depth, students in this study report their courses perpetuating a deficits-based outlook on Indigenous health as is seen elsewhere (see: Public Health Agency of Canada, 2018). Allan and Smylie (2015) note that attempts to change this

within various Canadian sectors, including education, have been minimal. However, this should not continue to be the case as many institutions have moved to adopt the recommendations of the TRCC. Lastly mentioned as hindering preparation was the distributed learning model specific to the UME program. A study by Burrows and Laupland (2021) reveals how distributed education for a British Columbian UME program led to students across the program receiving inequitable learning resources and experiences. This could be happening across the Lakehead University case as both the UME and BScN programs utilize forms of distributed learning which has the potential to fail at diverting resources and instructional capacity away from larger academic training centres (i.e. the university and local clinical placement settings) to their satellite campuses and remote community placement locations in a way that is accountable and closely monitored—as was seen by Burrows and Laupland (2021). This means that clinical environments, preceptors, and instructors in these distributed learning environments may not have the same educational priorities as the institution and its programs (e.g. role modeling of SRSJ for students and active involvement in related SRSJ initiatives).

Additionally, some students completely rejected the idea that their current programs had prepared them to work as a just and socially responsible provider, pointing to previous education or personal background being the sole contributors. This is unsurprising given some of the academic, professional and extracurricular backgrounds as well as identities that students reported having prior to their current enrolment (e.g. studying and working in Social Work, Public Health, Indigenous studies; volunteering in impoverished communities; or reporting a minoritized ethnic, gender, or sexual identity). Such backgrounds may lend students to being more critically “activated” as Novak et al. (2022) point to within their study examining an anti-racism project in UME. In their study, Novak and colleagues (2022) relay that students entering

UME programs may be placed on a spectrum of critical consciousness that can affect their ability to acquire particular SRSJ concepts (in this instance, anti-racism). An interesting point to consider is that which surfaced in a handful of UME student interviews of personal interest and responsibility when it comes to contributing to such work. These diverse student identities and personal commitments to SRSJ work are important to consider, as Verbree et al. (2023) posits, to diversify health professions education and in turn bolster learning outcomes and eventual healthcare outcomes. A few students pointed to how their preparation is due to the fact that they are committed to working towards health equity and that not everyone will be prepared because they simply have different goals for their work and the profession. Requiring such personal stake in this work is reflected elsewhere, for example in Hosseinzadegan and colleagues' (2020) work looking at how Iranian nurses enact social justice in their practice. In this study, it was mentioned that having certain personality traits such as a "justice-seeking spirit" contributed to nurses' work in this vital area. While not much work has looked into the identities of students with regards to their preparation to enact SRSJ-related work in health professions, there has been some traction in this area. More work is required to explore this subject.

Are Students Encouraged?

The last point to be addressed in terms of the research question is whether students feel encouraged to work as just and socially responsible HCPs. The definition of the word encourage has various interpretations. Merriam-Webster defines "encourage" as "to inspire with courage, spirit or hope". The Britannica dictionary defines it as "to make (someone) more determined, hopeful, or confident". Cambridge dictionary relays a definition of "to make someone more likely to do something" or "to talk or behave in a way that gives someone confidence to do something". Themes that surfaced throughout the data at times appear to relay that the inspiring

of hope or giving confidence to students to continue to provide just and socially responsible care is absent from these cases. While students feel inherently prepared as they have been formally educated, have gained experience in hands-on practice, and will in the near future earn a certification, they may not feel encouraged by their programs and environment to consider SRSJ concepts in their work upon graduation.

Feeling a lack of encouragement to work on SRSJ may be due to many of the reported findings including: hidden curriculum in the classroom and clinical environment that directly contradicts learned curriculum on such concepts; a lack of faculty and program support when challenging problematic curriculum and practices; a devaluing of such concepts throughout the program structures and evaluation methods; and having instructors that are not role-modeling or championing such efforts in the healthcare field. Such barriers to uptake have previously been raised. Hopkins et al. (2018) and Paul et al. (2018) for example, have described the hidden curriculum seen among various healthcare professions training programs. The crucial consideration of role-modeling and instructors' identities on students' confidence to utilize such concepts has also been discussed by Cruess et al. (2008) in their paper investigating role-modeling's effects on health professions education. Faculty not exemplifying or role-modeling SR was noted by nursing students in a study investigating nursing students' perceptions of SR in the United States (Shannon, 2017). Cruess et al. (2008) explain that "role models are different than mentors… [as they] inspire and teach by example" (p. 718). This is important to consider as the very nature of encouragement is inspiration—which the authors purport is a key component of role-modeling. Other studies have demonstrated that a lack of professional experience and knowledge regarding SRSJ-related topics among faculty in UME was found in a review of UME programs across three countries including Canada (Dogra et al., 2009) as well as in another study

conducted in the Netherlands (Verbree et al., 2023). The role of critical levels of burnout amongst HCPs is also important to consider as a barrier to having competent and willing role models. As HCPs are asked to do more with drastic staffing shortages, cuts to funding, and decreased resources (Glazier, 2023; Registered Nurses' Association of Ontario, 2022), their role modelling capacity may be diminished.

While not much is seen in the literature regarding students' challenging of curriculum, the research by Verbree et al. 2023 indicates that students are not being encouraged to engage in such discussions in their programs. Other work has also pointed to the lack of value placed on these concepts, for example, within the paramedicine profession (O'Meara et al., 2014) and UME (Dogra et al., 2009) rendering it unsurprising that such lack of value or even devaluing of SRSJ was found in this study.

While these findings may be viewed as difficult given the suggestion that students are not confident in their ability to employ SRSJ in their future work, there is a deeper level to why such findings may be present. As discussed in previous sections, the implications of the environment (i.e. clinical environments, classrooms, etc.) and what is seen or not (in terms of exemplifying SRSJ in practice) may be influenced by critical levels of burnout, unsafe staffing workloads (Registered Nurses' Association of Ontario, 2022), and chronic underfunding and defunding of education and healthcare (Canadian Association of University Teachers, 2021; Canadian Federation of Students, n.d.; Financial Accountability Office of Ontario, 2023). Continued lack of adequate funding, underfunding and defunding work together to create unsafe work environments at a baseline, meaning that when students are brought into the clinical environment, they may be interacting with HCPs who are facing the effects of burnout and who may not be actively working on SRSJ as they face higher caseloads and demands yet receive the

same if not less support to do so- they are in other words asked to do more with less. Again, this increase in workload is likely also seen in the classroom as postsecondary institutions continue to face cuts to their provincial funding all while being encouraged to increase enrolment numbers (Canadian Association of University Teachers, 2021; Canadian Federation of Students, n.d.). All of this coupled with the impacts of the COVID-19 pandemic, which has changed both the healthcare (Registered Nurses' Association of Ontario, 2022) and education landscape (Statistics Canada, 2020), combines to detract from what could otherwise be a supportive learning environment.

In relation to disseminating SRSJ to healthcare professions students, it is clear that students feel varying levels of preparation, informedness, and encouragement from their programs. However, being informed but not encouraged, or being encouraged but ill-informed or unprepared to utilize such concepts may result in a lack of uptake of these concepts and subsequent perpetuation of the status quo of current healthcare practice. As Plamondon (2020) states in their paper looking at developing a tool to assess the link between knowledge and action on health equity among healthcare professionals and students: "good intentions and good evidence do not necessarily lead to meaningful action" (p. 1). Because of this, some have pointed to the need for transformative learning which goes beyond "humanism" and "social constructivism" and instead engages the learner in heutagogy[27], directing themselves to determine their knowledge gaps and seek out answers (Low et al., 2021, p. 5). Furthermore, Novak et al. (2020) relay that partnership between medical faculties and medical students is essential to progressing the dialogue regarding anti-racism in UME. This means students move

[27] "In a heutagogical approach to teaching and learning, learners are highly autonomous and self-determined and emphasis is placed on development of learner capacity and capability with the goal of producing learners who are well-prepared for the complexities of today's workplace" (Blaschke, 2012).

beyond the learner role and instead take on an educational role for their student community–moving beyond social constructivism wherein they are negotiating meaning with an instructor, and moving into transformative learning wherein a more critically activated student may serve to be an educator in their own right, and a changemaker within their educational program or institution (Novak et al., 2020).

Taking a Closer Look at the Cases

When looking at the literature regarding health professions education frameworks, there are a handful of different approaches related to the training of HCPs to work towards the concepts relevant to this study. The main framework and concept within the literature surrounding such work is SA (social accountability) as has been mentioned throughout this work. SA, while a part of the topic for this study, does not encompass the more holistic focus of SRSJ which has a broader inclusion of concepts such as social justice, advocacy, intersectionality, critical consciousness, and CS, among others. However, as much of the literature is siloed, looking at only one concept at a time, SA is referenced heavily as a guiding framework for analyzing how health professions programs teach, prepare, and encourage SRSJ in practice within their students (see for example Table 4).

SA has many different facets with an overarching goal of promoting improved health outcomes for the populations that its institution serves. As a guiding framework, SA promotes partnerships at various levels such as that of the community, healthcare professionals, and other key stakeholders. Additionally, SA recognizes that educational institutions should be directing education, research and service towards work that contributes to the betterment of the community it intends to serve (Boelen, 2000). Further considerations of how SA is often embodied within programs can be seen in Table 3. While SA is particularly heralded by UME,

SA is merely used as a framework to guide discussion of the findings here given that students within this study are enrolled in other programs outside of UME.

In the WHO document *Challenges and Opportunities for Partnership in Health Development* (2000), Boelen proposes a grid to evaluate SA on 4 measures: quality, equity, relevance, and cost-effectiveness. Use of this grid allows for assessing "the extent to which… [the three domains of education, research, and service] contribute towards building a health system that is relevant to the needs of the community or nation and provides high-quality health services that are cost-effective and equitable" (Boelen, 2000, p. 43). This study looks at the "most modest commitment [of]… the *planning* phase, in which a school demonstrates—by means of the content of its mission statement, or the way departments are organized, or the way resources are allocated—that it intends to undertake socially accountable actions" (Boelen, 2000, p. 43). Under investigation is also the "*doing* phase [which] involves more commitment… [as] a school shows that it is implementing the planning phase" (Boelen, 2000, p. 43). While this study is not a program evaluation and is looking at the broader SRSJ, this grid is used to conceptualize current educational practices and where programs may best improve to better inform, prepare, and encourage students to work towards just and socially responsible care. It is also important to consider that efforts to address improvements may require support from the academic and healthcare institutions implicated within these cases. However, as was discussed previously, both postsecondary education and healthcare systems within Ontario have been overwhelmed with cuts to funding and resources while also being required to pivot policies and practice to continue operating during a global pandemic. Thus these institutions will also require support to help improve their efforts—possibly though adequate funding, or governmental resources.

Figure 6

The SRSJ grid

VALUES	**DOMAIN AND PHASES**		
	Education		
	Planning	Doing	Impacting
Quality			
Equity			
Relevance			
Cost-Effectiveness			

Note. Adapted from the expanded social accountability grid (Boelen, 2000).

Focusing on the *Education* column in Figure 6, there is the consideration of “planning”. As Boelen (2000) states, this includes a demonstration by the educational institution that SA– or in the broader focus of this study, SRSJ, are key concepts of the program and are to be disseminated as such. From student reports and an online environmental scan, it is evident that the only some programs across the cases are perceived to have *explicit* mandates revolving around SRSJ. This is an important point of consideration given that mandates such as SA (as seen within the UME program) implicate all levels of the educational institution in working towards the goal of SA—the institution, the instructors, the researchers, the students. Yet, in order to ensure such efforts are directed, institutional buy-in and regulation of implementing such goals into the curriculum and programs may be required. Similar findings are seen with the need for such buy-in to implement support for diverse learner populations in a research report by

Taylor et al. (2022) investigating the implementation of and support for more diversity within health professions training programs across the United States. Thus such buy-in is applicable to the planning of implementing SRSJ initiatives across health professions education.

In terms of the "doing" column, students' reports relayed that programs were incorporating various components related to implementing SRSJ theory and practice. (Refer to Table 4 for a more in-depth list of these components). Of particular interest is the mention of diversity of the student body as seen through reports of stimulating conversations in the classroom—an idea reported predominantly within the Lakehead University case. This points to recruitment of a diverse student body to help diversify the healthcare workforce, something that is argued to be of great benefit in improving health outcomes and is being advocated for within the literature and policy (see: Truth and Reconciliation Commission of Canada, 2015) (Taylor et al., 2022; Verbree et al., 2023). While a perceived lack of diversity among the faculty and staff was reported, it may be beneficial to re-examine recruitment measures for both students and faculty to each of the programs– considering how such diversity was reported to bolster learning outcomes in this study. A focus on diversity that is not only ethnically-based, but also considers multiple identities would only further the types of discussions heard in the classroom and aid in uptake of concepts, potentially creating more socially just and responsible graduates of each of the programs.

Other important components of implementing SRSJ seen through students' reports was the use of diverse clinical and community engagement opportunities (outside of routine clinical placements in hospital and long-term care settings). Students particularly in the UME program reported having extensive community engagement through community placements across the northern Ontario region starting in the first year of their four-year program. Another report of

such opportunities was provided by a BScN student within the Lakehead University case who mentioned having the opportunity to partake in a rural clinical placement. However, no other mention of such engagement opportunities with the local community were mentioned other than further examples from the UME program where students also mentioned opportunities via additional interest groups (e.g. the Indigenous health interest group) which afforded students further opportunities to partake in community engagement. The importance of community has been touched on in various papers in terms of contextualizing future healthcare practice to form more socially responsible providers (Ross et al., 2014; Ross et al., 2019). In one Australian scoping review investigating health professions education aimed at addressing remote and isolated community health needs, the importance of “remote teaching” for these programs was found (Reeve et al., 2020). This paper highlights the relevance of place within learner formation specifically aimed at SA (Reeve et al., 2020). Similar findings were reported by NOSM University students in a study looking at preceptors’ and students’ opinions of their time in rural community placements (Ross et al., 2019). In this paper, students reported valuing their time in rural placements as it prepared them for future clinical placements and eventual medical practice, allowing them to gain a sense of place and context in unfamiliar locations (Ross et al., 2019).

In addition to these components that have been implemented, students within the BScN and UME programs reported the use of stakeholders and other professionals educating them on topics of interprofessional collaboration (i.e. other HCPs) and concepts such as CS (i.e. stakeholders and rights holders[28]). Additional reports of curriculum relevant to SRSJ as

[28] The idea of rights holders is mentioned by the Indigenous Corporate Training Inc. as an alternate term for referring to Indigenous peoples who act as what is commonly referred to as “stakeholders” (2018). The use of the term rights holders rather than stakeholders recognizes that Indigenous peoples do not merely stand to be impacted by a project or initiative. Rather Indigenous peoples have constitutionally-protected rights and as such play (or have the right to play) a much larger role in the development process of a project that is not limited to knowledge contribution.

presented by stakeholders or experts in their field were mentioned (e.g. a guest presenter on supporting individuals using opioids, or marginalized community members talking about their lived experience navigating the healthcare system). Inclusion of outside professions and community voices is integral to the integration of SRSJ-related frameworks and can be utilized to incorporate just and socially responsible care concepts into health professions education as well. The importance of this inclusion has been mentioned by stakeholders and rights holders on Indigenous health in Canada (Beavis et al., 2015); Ontario health professions students learning about Indigenous CS (Shah & Reeves, 2015); Australian academics looking at Indigenous CS measures within health professions education (Kickett et al., 2014); and researchers examining UME community-based curriculum in Israel (Essa-Hadad et al., 2015). However, it is important to note that while students were receiving this knowledge from stakeholders and those actively involved in SRSJ-related work, there was a perceived lack of work and personal diversity across the program staff. It is important to highlight that this lack of diversity amongst instructors is perceived, and identity is not something that is inherent to all. That is, students cannot understand the depth of the instructor's identities by merely looking at them. It is also important to consider that students felt more supported by staff who appeared to be younger and who employed more engaging teaching styles. While it is plausible to consider that feelings of support and engagement are due to teaching style, the instructors' age may play a role in how students feel they can relate to the instructor. As Cruess et al. (2008) argue having instructors who are able to serve as role models creates representation and encourages students to see the importance of SRSJ within their profession. Thus while some students saw younger faculty and instructors as role models, the same might occur with faculty and instructors who share other similar identities with students (e.g. ethnicity, personal and research interests, etc.). It is simply a

matter of whether students are aware of those identities and may be able to relate to them in some capacity. It is also plausible to consider the reported findings given that students heavily focused on feeling supported by younger faculty and instructors—it is possible that relating to the younger instructors resulted in students not focusing on the diversity amongst older staff that may be present.

Additionally, some students, particularly within the UME program, also mentioned how facilitators of SRSJ-related discussions were often not role models from their own field. For example, UME students were not being taught SRSJ by physician academics, but rather other HCPs facilitating CBL discussions. This is important to consider when students also report not seeing physicians and other HCPs acting on SRSJ within the clinical setting. Not seeing faculty upholding what they teach is something that may fail to support students' acquisition of concepts as Wrenn & Wrenn (2009) purport in their paper looking at the effect of instructors' integration of theory into practice on learning. Similar claims have been made by Cruess et al. (2008) in their paper on role-modeling's importance as a teaching strategy and by Shannon (2017) who found that nursing students desired more role-modeling of SR by practicing nurses.

Additional points of contention between the data and what Table 4 and pertinent literature suggest for implementing SRSJ in health professions education were seen. While some programs check the boxes for multiple of the considerations within Table 4, such as inclusion of community and community voices; diverse clinical opportunities; integrating SA (or in this case SRSJ) into curriculum; and incorporating information relevant to underserved communities, there continues to be obvious gaps and room for improvement across the programs. These gaps include a lack of commitment to and valuing of SRSJ across the institution, faculty and staff; a lack of emphasis on SRSJ as a main tenant of the programs within each case; and a lack of

diversity among faculty and instructors as perceived by students. Findings that were largely different from what has been reported in the current literature and may require further investigation include: students' unpreparedness and learned helplessness related to working with diverse patient populations; the influence of personal and professional background on students' preparedness to enact SRSJ; the definition and practicality of advocacy as it relates to health professions education outside of UME within Canada; and the lack of value placed on SRSJ across health professions education.

In utilizing Boelen's social accountability grid, attempts to plan, implement, and evaluate SRSJ within health professions education may be more easily envisioned and facilitated. In alignment with the research question of this study, this grid helps to evaluate the *impact* of current efforts to implement SRSJ within education across the cases which may help students feel *informed, prepared,* and *encouraged*, while also paying attention to how the *planning* and *doing* of each case has resulted in students' sense of preparation. Intentional planning and doing that may aide in such outcomes include: institutional mandates and commitments to SRSJ as exemplified by diversity among faculty and staff; explicit messaging and goals aimed at SRSJ as embodied by graduates; and required SRSJ-related coursework for students). Additionally, to specifically *encourage* students, the use of role-modeling by faculty, staff, and clinical instructors, as well as valuing of SRSJ across the cases is vital.

Implications

Findings from this study provide insight into areas of potential improvement for both cases in relation to educating students to work towards health equity as just and socially responsible future HCPs. For simplicity, considerations are listed according to each case. The most prominent areas for potential improvement is that of having explicit faculty, staff, and

institutional commitment to SRSJ; promoting community engagement; and addressing community needs through education, research, and clinical experiences. All of this should also consider the need for the cases' support in the way of funding and resources from provincial governing bodies. These considerations are not to be solely the burden of the cases. The first point appears to be contradicted by what students report as a perceived hyper-focus of program curriculum on Indigenous health and lacking other purposefully marginalized groups' health concerns in curriculum; reports of instructor biases impacting the learning environment and dissemination of concepts; a perceived devaluing of curriculum regarding SRSJ via altered grading schemes (Confederation College) or lack of role-modeling by instructors and preceptors (Confederation College and Lakehead University); and reports of hidden curriculum as disseminated through direct contradiction of the concepts of concern, often in clinical placements. Community engagement is perceived to be lacking according to students' reports (except the UME program), with students reporting a desire for more engagement. The impact of community engagement on students' familiarity with SRSJ-related concepts can be seen for example when looking at the different levels of familiarity reported by PCP students and UME students. Whereas PCP students report only one dedicated course touching on SRSJ, UME students' program is entirely centred on SA and as such report much more programmatic content dedicated to SRSJ and familiarity with SRSJ concepts compared to PCP students. The consideration of community engagement is important as it is something that can be incorporated and encouraged by the individual programs within each case and may improve students' understanding of the importance of SRSJ within the healthcare sector. The consideration of addressing community needs through the educational institution's efforts appears to be lacking across the cases given reports of most instructors having no direct relation to the concepts they

are teaching on as perceived by students (i.e. working in advocacy work, doing research on the community's needs and incorporating that into the curriculum, having lived experience as a visible minoritized person).

Considerations for Confederation College

Despite the institutional direction afforded through CC's strategic plan and other guiding documents, there appears to be a disconnect between what is to be the outcome of these plans and what is perceived by students. Given the disconnect between the case and frameworks on implementing curriculum that aligns with SRSJ (or SA) within educational programs, as well as the idea that concepts relevant to social justice and social responsibility (or SA) are to be mandated (Boelen, 2000) and evident at various levels within the academic programs (Abdalla, 2014; Ross et al., 2014; Rourke, 2018), there are a number of considerations for the Confederation College case. They are as follows:

1. *Valuing these concepts in practice*. While concepts such as intercultural competency and Indigenous curriculum are highlighted in CC's guiding documents, as per student reports, there is a need to revise some of the praxis behind these goals. This might best be done through a revised grading scheme for courses that touch on these topics (e.g. the course *Human Diversity*). Additionally, integrating concepts in a way that is perceptively meaningful and intentional into courses throughout the length of programs may also relay their value and importance to providing equitable patient care (also seen in Beavis et al., 2015). This has been mandated with Indigenous health concepts throughout the institution as noted within the case setting description (refer to section: *Taking a Closer Look at the Cases)*. However, continuing on this trend with other important concepts such

as CS, intersectionality, and critical consciousness may help promote SRSJ within the student body.

2. In conjunction with the last consideration, *increasing students' exposure to just and socially responsible care concepts*. This can be done by incorporating these concepts more frequently into lessons and including them as learning objectives for clinical placements and clinical debriefing activities. Integration of concepts into core curriculum across the duration of academic programs has been supported elsewhere (see: Fung & Ying, 2021; Forsyth et al., 2019a; Goez et al., 2020; Reitmanova, 2011). Furthermore, concepts should be expanded upon instead of briefly touched on, and lessons should focus on the practicality of these concepts in working towards health equity (e.g. applying intersectionality or cultural safety to understanding power dynamics in the clinical setting).
3. Establishing *a commitment to promoting just and socially responsible practice* by way of mandates, mission statements and policies supporting inclusion of these concepts (see for example: Rourke, 2018; Paul et al., 2018). Such mandates and policies should be directed at curriculum as well as recruitment efforts for both students and staff (i.e. promoting diversity within the classroom and representation from various backgrounds). Recruiting staff and students of various backgrounds into targeted programs (i.e. professions, educational backgrounds, ethnicities, ages, etc.) will serve to bolster the acquisition of concepts as evidenced by this work and other literature (Dickson & Manalo, 2014). While the strategic plan has focused on recruitment and diversification as well as supporting the inclusion of global citizenship and Indigenous health related curricula, it may be beneficial to continuously monitor these efforts and the outcomes as a result of

such efforts to inform next steps and other potential concepts to promote that continue to further the promotion of SRSJ among students.

Considerations for Lakehead University

While there is some overlap between cases, Lakehead University as a case is interesting given that one of the programs (UME) has an explicit SA mandate and purportedly does much work along the lines of promoting just and socially responsible practice by way of this mandate. Despite this, students' perceptions of their preparation across both programs relay that there is still work to be done to promote such concepts across the case. While some students report having certain parameters (from Table 4) met within their program, students from the other may report not seeing these concepts exhibited. Additionally, these considerations may require alterations in application to the UME program which is now officially a standalone medical university as established in April of 2022 (NOSM University).

1. Firstly, a *commitment to promoting just and socially responsible practice particularly within the health professions* may be beneficial. This can be done through implementing program-level mandates and mission statements, and defining programmatic goals with strategic plans specifically for health professions programming. Such institutional buy-in is supported such as with inclusion of SA mandates (see for example: Rourke, 2018; Paul et al., 2018). While strategic planning that includes the importance of social responsibility and community engagement is in place for the institution as a whole, additional considerations and academic planning may be beneficial for specific programs (i.e. program-specific goals and strategic plans that align with SRSJ and are readily available to the public to view). It is also crucial that programs have the support and resources to be able to make this happen, in the way of adequate funding and resources,

as well as healthy partnerships with clinical institutions for placements. This last point means that the institutions in the Ontario healthcare system must also obtain the necessary funding, staffing, and supports to operate effectively and to be able to successfully host learners.

2. *Establishing space and systems of support* for students who report instances of unsafe and unethical patient encounters or instances of discriminatory or derogatory application of these concepts (e.g. hyper-focus on Indigenous health curriculum that is deficits-based). This may look different depending on the program and stage in which students find themselves (i.e. pre-clinical or clinical placements). However, establishing a space and (potentially anonymous) process for handling complaints against the institution or its various components (programs, instructors, partners, etc.) may help students feel safe to voice their concerns as well as to be supported in acting on concepts of social justice and social responsibility while still classified as a learner. While formal complaint processes are in place for violating university regulations, as well as for advocacy type efforts (such as an ombudsperson within the hospital and academic institutions), it may be difficult to reconcile the complaint of microaggressions and negative/discriminatory hidden curriculum. This is especially the case for students who may feel fearful of voicing their concerns within their professional programs where faculty and instructors may later become colleagues of program graduates, and where clinical placement locations may be where students intend to work upon graduating. Although work on the concept of hidden curriculum and it's implications for nurses in particular has been conducted (Karimi et al., 2014; Raso et al., 2019), additional research focusing on supporting students to reconcile this negative hidden curriculum might be valuable, as seen in one study by

Kelly (2020) which indicated that teaching students about hidden curriculum helped to reinforce their confidence in identifying unsafe nursing practice and to report it as such.

3. *Diversifying the learning environments*. This consideration comes from student reports of faculty and instructors lacking perceived cultural or ethnic diversity. Additionally, participants pointed to enhanced engagement when their fellow students had diverse backgrounds and life experience to help promote dialogue around just and socially responsible care concepts (this has been reported elsewhere as well: Dickson & Manalo, 2014). While these diversification intentions are a part of the strategic plan mentioned in the literature review, continued efforts to work towards increased diversity may be warranted. In addition to recruitment of diverse instructors and students, further and explicit promoting of the option for non-traditional clinical placements for students (e.g. rural placements and public health placements) may help the acquisition of such concepts (i.e. further engaging students in place-based curriculum) (see for examples: Abbott et al., 2020; Kaufman et al., 1979).
4. *Evaluating distributed learning models*. While both of the programs within this case (BScN and UME) utilized some form of distributed learning (e.g. community-based BScN, rural clinical placements for UME learners), there are various reports of students feeling as though the concepts learned in the classroom are not being fully supported in these distance-based settings or that they are unable to connect the dots in placement between theory and practice. This points to a potential lack of consistency between the classroom and community placement partners. The institution should assess gaps in the support offered by community partner organizations and opportunities (i.e. community placements, clinicals, etc.) that may help students hone their just and socially responsible

care concepts when not located directly on campus. This may look something like weekly debriefs with the main academic institution (e.g. BScN faculty on campus via Zoom), or potentially requiring facilitators on the ground who are committed to just and socially responsible care who can act as support for students. Additionally, ongoing evaluation and monitoring of these supports and their impact should be incorporated.

Limitations

Given the qualitative nature of this study, this work is not generalizable, and findings should not be separated from the context within which they arise. The samples garnered within each case are fairly ethnically homogenous, and consequently may unintentionally exclude experiences from a significant proportion of the student bodies. Additionally, this work is not a program evaluation but constructed as a qualitative case study limited to the perspectives of students. This alone may limit uptake of the considerations stemming from this work. Furthermore, as a multiple qualitative case study, findings and considerations are presented separately; however, this is not to be misconstrued as a program evaluation. The presentation of the material herein is as such given that the data should not be separated from their individual contexts, as stated previously.

Additionally, as an outsider to these programs, knowledge on programmatic features, mandates, and practices is limited to what can be sourced from online sources and interviewees. As a critically-oriented researcher, data interpretation may be skewed by my personal bias (e.g. seeing institutions as perpetuating the status quo and not furthering work in SRSJ, when significant improvements could have been made by the cases over the years). However, outsider status is not solely a limitation as it may also have allowed me to have a more objective perspective when analyzing the data and the ability to feel freeer in my reporting of the findings

☺. Furthermore, limiting the data collection to student interviews has limited the ability to more fully triangulate findings within this study as other perspectives are excluded (e.g. faculty and staff perspectives). Further research looking at how to bolster learning outcomes around just and socially responsible practice may require additional stakeholder input on how to effectuate the considerations listed previously. Additionally, qualitative program evaluation methodologies (in lieu of case studies) may best serve to enact such change should it be deemed necessary by stakeholders.

Lastly, the role of student identity played a major part throughout many of the themes within this study and the consequent analysis. While this study was constructed as a qualitative multiple case study with a social constructivist approach and the identities of participants were sought to more fully understand their perspectives, it is important to consider that identity formation is constantly evolving (Lawy, 2003). This study as stated previously, is a snapshot in time of how students perceive their academic experience and how their identities at that point in time interplay with their preparation, informedness, and encouragement to work on SRSJ. These three components may change overtime as students progress throughout their programs and practice and as their identities change from learner to professional (Findyartini et al., 2022). Thus another limitation of this work is the timeframe for data collection. To more fully understand the complexity of the interplay between identity and preparedness, a longitudinal cohort study may best be utilized. Additionally, with the consideration and inclusion of identity throughout the data, concerns surrounding anonymity arise. As such, the findings were unable to be attributed to particular identities. For example, while those who reported a particular identity may have also reported a particular perspective on their education, it was imperative that particular intersections of identities and academic experiences were not directly tied to one another to preserve the

participants' anonymity. Such a limitation may result in a stinted discussion that inhibits the ability to apply an intersectional approach to the analysis of the data herein. This is important to consider when conducting research with a population such as students given the unique position they are in within the classroom.[29]

Reflections

Upon starting this research project, I held many ideas and biases. For example, the work started out as solely examining the idea of SA within the health professions. However, as I continued to investigate current initiatives across the health professions, it was found that the language of SA is not a commonly shared one. As such, reworking of the initial structure and verbiage was warranted. I also found that I was conceptualizing the idea of SA as the best practice to work towards—probably due to my bias of being close to the UME program here at Lakehead University (NOSM was the first school of medicine to be founded with an SA mandate). Further I initially had intentions to continue my academic career in medicine.

The limitations of solely looking at SA were brought to my attention upon review of my REB application by the Dean of the Faculty of Health and Behavioural Sciences, who simply pointed to the verbiage of SA being problematic when interviewing students from programs that may not employ that term or concept within their programs. While at that time it was simply a matter of verbiage and politics, it soon became clear that there was more to this point than simply word choice. The world of health professions education, I have found, is constantly evolving. New terminology, concepts, and curricular foci emerge every decade if not sooner as the best

[29] In Bell Hook's *Teaching to Transgress*, she writes that students are often at odds with the instructors of the classroom given the different social backgrounds that they come from. Due to this, there is an inherent power imbalance wherein "bourgeois" class ideals are upheld by the academy and the instructors (who often are of a more privileged socioeconomic background) as students are silenced and made to obey the rule of the classroom.

practice for a field. It was seen with the transition of multiculturalism to CC to CS. And can be seen across the professions with differences in programmatic foci depending on one's field. Thus, this study simply put, is *complex*. However, with all these terms used by various fields, it leaves room to wonder, why do professions attach themselves to one particular concept or lens?

As I reflect on my work, I am called to question the very notion of pushing forward the agenda of SA for example, which may limit a program or institution's openness to implementing other practices to work towards the same goal of socially just and responsible care. I believe many reading this work will be thinking what I was at the outset of this research project: is it simply the need to have direction which guides the academic institution to adopt particular frameworks and to fail to implement others? Is there a "best" practice for each health professions field? What is the right combination or ratio of each particular SRSJ-related concept or framework to create a just and socially responsible HCP? And I think in response to all of these I would say: I do not know.

I believe my work has made me realize that there is a need for academic institutions and programs to have continuous conversations about not solely *what* they are teaching, but *how* they are teaching. There is a need to constantly ask: "why are we mandating X requirements in the curriculum?" And "are the outcomes matching the intentions?" In other words, there is a need for consistent conversation within and amongst faculty and staff as well as between faculty, staff and students to ensure that current program directions and initiatives are doing what they are intended to (and whether that is leading to capable and confident learners).

All of this said, through my work I have truly come to understand that we do not live in a binary world. We live in the grey in-between. There are many aspects to consider when we think about research, practice, and essentially everything. For this work, that looks like the context of

the COVID-19 pandemic, the rocky healthcare and postsecondary landscape of Ontario, as well as my perspectives as an outsider to the programs from which my participants are recruited. As someone who identified as being critical at the outset of this work, it was not until I was pushed to rethink my analysis and the contextual pieces that lend to the greyness of qualitative research that I realized how *un*critical I truly was.

There are other reflections which have since come to mind such as my personal journey throughout the research process and my journey following the completion of this work. During the initial conceptualizing of this work, I had grand plans of wanting to figure out how to make all health professions programs socially accountable—a reflection probably of my massive desire to attend the UME program within this study at that time. However, over the course of the two years, I came to find that not only was SA not the answer for every health profession, but UME would not be where I ended up. As I end this research and enter my next chapter of life, I find myself in a way, full circle and headed back into nursing (where I originally began my humble post-secondary journey, before changing my major years ago). Whereas when I first entered nursing as a young 17 year-old, I am now an experienced student who is trained to be reflexive and who has studied the very experiences of those before me in the same program I now attend. My graduate journey and research has made me all the more critical—not of the program I am now in, but of myself and what I bring to the table in terms of my identities and how this will impact my uptake of the curriculum.

Conclusion

The findings discussed in this study represent a snapshot in time that illustrates participating students' perceptions of how prepared they feel to work as just and socially responsible providers upon graduation. What can be seen are varying opinions on preparation,

however with an overall sentiment that more can and should be done by the academic institutions to promote informedness, preparation and encouragement to utilize these concepts in practice.

From each case, students spoke of a multitude of components within their education that worked or did not work to inform, prepare, or encourage them to work as just and socially responsible providers. From the Confederation College case, students spoke of 1) feeling that preparation is due to many different things; 2) an inherent (de)valuing of the concepts relevant to just and socially responsible care; 3) the program contextualizing the curriculum to place (i.e. NWO); 4) only scratching the surface of SRSJ within the curriculum; 5) experiencing varied didactic styles and as a result having varied learning outcomes; and 6) seeing instructors' identities influencing acquisition of concepts. From the Lakehead University case, students mentioned 1) how the feeling of preparation was due to a constellation of components including their own personal background as well as their academic program; 2) the potential for students to fail at converting theory to practice due to the inconsistency of delivery within their programs; 3) an (un)supportive learning environment; 4) the programs contextualizing the curriculum to place; 5) feeling as though programs were checking the boxes in terms of including curriculum relevant to priority populations' health concerns (e.g. Indigenous health); 6) prioritizing SRSJ-related concepts during the theory portion of the programs and less so in the clinical phases; and 7) the instructors' identities influencing students' learning. Through all of these findings, it was seen that the majority of students across both cases generally felt informed, but perceived their education as inadequate in fully preparing them to actualize the information learned within their programs. Through the themes relaying unsupportive learning environments and devaluing or undervaluing of these concepts, it was seen that students were also not encouraged to pursue such work upon graduation as future HCPs.

Implicit within the findings (and elaborated on in the discussion) is the nuance that structural factors contribute to the outcomes of this study. For example, while students may report feeling that SRSJ is undervalued in the clinical components of their education or not talked about enough throughout the curriculum, the current political landscape of underfunding and staffing shortages is highlighted. That being said, there is much to consider regarding the findings of this study. They are not clearcut, and should not be interpreted as such but rather contextualized to the time and place in which the study was conducted—which is two provincially-funded post-secondary institutions in the aftermath of a major epidemic which drastically changed funding allocation, public health precautions in clinical settings, and the political and academic landscape.

The findings are not comparative. Rather, the institutions from which the participants were recruited may choose to use the findings to determine whether an examination of their current practices could be beneficial. Such an examination could be inclusive of but not limited to: institutional policies such as admissions policies; equity, diversity, and inclusion policies; recruitment policies for staff and faculty; curriculum requirements including grading schemes, mandated inclusion of SRSJ-related concepts, how curriculum encourages engagement on a higher level of thinking (e.g. debriefing and critical reflection); and how clinical placement requirements could be encouraging and supporting SRSJ among students (e.g. having committed clinical instructors and preceptors, establishing space and time for reflection and debriefing, and promotion of SRSJ by the clinical environment or host organization).

While considerations are outlined in the previous sections, they are not exhaustive. Further work may be needed to engage key stakeholders within each case, encouraging a dialogue of continuous improvement to see how these considerations may best be implemented

or altered according to each case's needs. However, it is key that future work continues to centralize student voices as this area of work particularly relates to their academic preparation and their perspective is crucial to understanding what is working and of course, what is not. From the literature review it is also evident that more work is needed assessing the role of learner identities in academic preparation, preparing competent and confident health professions graduates. Overall, this study provides insight into two educational institutions' practices for educating health professions students on just and socially responsible care concepts from the learner perspective, a critical lens for potential program improvement in this area.

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Appendix A
Literature Review Methodology

An initial literature review was conducted using five separate search engines, *Web of Science*, *CINAHL*, *PubMed*, *ERIC*, and *Education Source*. Additionally, snowball sampling of the works referenced in the extracted articles was done to ensure all relevant material was reviewed. Literature garnered throughout this process is predominantly peer-reviewed articles, though grey literature, editorial pieces, opinion pieces, and commentaries have also been included. Journals known to be critical in nature were also searched. Of thirteen critically oriented journals, 12 were found to be included in the major databases searched. One critically oriented journal, *Critical Intersections in Education*, was searched for additional relevant materials, from which one article was kept for extraction. Lastly, a quick environmental scan on GoogleScholar was performed to find any relevant articles that may have otherwise been missed. Aside from these more systematic searches, other articles were incorporated into the extraction as they were found relevant (i.e. 2 articles from Dr. Maria Mylopoulos, an experienced academic who works on curricular design for health professions students and HCPs).

The main database search was split into two separate search strategies, with the first three database searches (*Web of Science, CINAHL,* and *PubMed*) conducted utilizing similar query terms with slight variations and filters. After consultation with the university librarian, it was determined that education databases should be included as well, resulting in the latter two database searches (*ERIC* and *Education Source*) using different Boolean query terms from the initial search. Following discussion with my thesis committee, it was determined that an additional literature search was warranted looking at specific concepts not included in the initial search strings. These concepts included cultural safety, cultural competency, cultural humility, health advocacy, anti-racism, anti-colonialism, and intersectionality. The revised search was a

necessary step to ensure all relevant literature was found and could be used to corroborate or challenge the findings of this study.

The literature review was focused on finding studies reflecting current practices in primarily English-speaking countries that have ties to colonization either directly such as the U.S., Canada, South Africa, New Zealand, and Australia, or indirectly as the U.K.. In addition to the colonial similarities, each of these states contains large metropolitan areas that are ethnoculturally diverse, as well as rural areas–each of which pose different implications for utilizing SA curriculum components such as CS and SDOH in healthcare practice. The intent of this search was to see which pedagogical models are in use, and if particular models addressed students' needs in required knowledge to work with diverse populations within their respective regions. The following Boolean search parameters were used for the first search: *Web of Science* (((ALL=(Canad* OR US OR UK OR Australia* OR New Zealand OR South Africa)) AND ALL=(Social Determinants of Health Curricul*)) AND ALL=(healthcare professional OR healthcare student*)) AND ALL=(university OR college), search is limited to articles published no later than 2011; *CINAHL* (Canad* OR US OR UK OR Australia OR New Zealand OR South Africa*) AND (SDOH Curricul* OR Social Determinants of Health) AND (University OR College), search is limited to articles published no later than 2011; *PubMed* (((Canad* OR US OR UK OR Australia OR New Zealand OR South Africa*) AND (SDOH Curricul* OR Social Determinants of Health)) AND (University OR College)) AND (healthcare professional OR healthcare student*), search is limited to articles published no later than 2011 and English-language only. 778 resources resulted from the initial search following removal of duplicates, with 131 kept following title review and 75 remaining following an abstract review. 38 articles were included from this search in the literature review.

Following data extraction from this search, references were gleaned from each article. This resulted in 45 additional titles, 19 of which were included in the data extraction following abstract review. Knowing that pertinent information may not be contained within these prominent databases, a quick environmental scan was performed using a GoogleScholar search using the following terms “assessing students knowledge on sdoh in healthcare”, limited to 2011 on, and sorted by relevance. The first 10 pages of results were reviewed. 41 titles were kept for later review, 19 of which were included in the data extraction following abstract review. Lastly, articles from an expert in the field of medical education were gleaned that were considered to have relevance to the study parameters (studies from Dr. Maria Mylopoulos[30]), resulting in the inclusion of 2 additional articles to the data extraction.

In addition to these searches, the education databases were searched using different query terms. The searches were as follows: *ERIC* ((Social accountability OR social determinants of health OR SDOH OR cultural safety OR advocacy OR multicultural OR cross-cultural) AND (health professional OR allied health OR healthcare professional) AND (education OR curriculum OR program OR training)), search is limited with the following filters “postsecondary education”, “higher education”, “two year colleges”, “adult education” and publication dates between 2011 to 2021; *Education Source* ((Social accountability OR social determinants of health OR SDOH OR cultural safety OR advocacy OR multicultural OR cross-cultural) AND (health professional OR allied health OR healthcare professional) AND (education OR curriculum OR program OR training) AND (canad* OR north america* OR north*)), search is limited to publications from January 2011 to Dec 2021 and in English. 242

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[30] Studies from this academic were included as their work aligns with educational innovation in the health sciences and they work directly within UME settings as well as in other health professional education organizations—making their work applicable to many of the parameters this study is researching.

titles resulted after removal of duplicates, with 69 kept following title review, and 36 remaining following an abstract review. Only 5 were kept following full review. In addition, 4 other articles were found through a search in the same education databases using the same search parameters and date filter (2011-2021), but excluding the other search filters.

The third search included all previous databases: *Web of Science, CINAHL, PubMed*, *ERIC* and *Education Source*. The following search terms were used: (Canad* OR US OR UK OR Australia* OR New Zealand OR South Africa) AND (cultural competency OR cultural humility OR health advocacy OR anti-racism OR anti-colonialism OR intersectional*) AND (healthcare professional OR allied health OR healthcare student*) AND (university OR college) AND (education OR curriculum OR program OR training). A total of 2,240 articles resulted. Following title, abstract, and full article review, a total of 34 articles were kept.

In addition to the major databases searched, a search for journals with critical perspectives was conducted. It was found that a majority of the critical journal titles relevant to my focus were in fact included in the major databases. However, one critical journal specific to education *Critical Intersections in Education* was not included and thus was searched for relevant articles. 2 articles were found and 1 kept for full review and inclusion in the literature review. As publications are reviewed, data are recorded such as: research approaches, methodology, publication dates, and participant characteristics. Following full review of each text, emergent coding is performed, applying and relating common themes across the literature. These themes will be described in detail in the following subsections, and are gleaned in order to direct the construction of the research questions and methodology.

Appendix B

Flyer for Recruiting Participants from Confederation College

YOU'RE INVITED TO PARTICIPATE!

STUDENT PERSPECTIVES ON PREPARATION TO BE JUST AND SOCIALLY-RESPONSIBLE PROVIDERS:

A Northwestern Ontario Qualitative Case Study

Interviews via Zoom, in-person or self-recorded!

Fill out the form with your information to participate:

https://bit.ly/3shGT8r

Who's eligible?

LOOKING FOR:

Students currently enrolled at least part-time in one of the following programs:

- Paramedicine
- Practical Nursing
- Collaborative BScN

*Must have completed at least one academic term within your program prior to participating, preference given to those who are upperclassmen.

***This study has been reviewed by Lakehead University's REB #1469388 and Confederation College's REB #0108**

Appendix C

Flyer for Recruiting Participants from Lakehead University

YOU'RE INVITED TO PARTICIPATE!

STUDENT PERSPECTIVES ON PREPARATION TO BE JUST AND SOCIALLY-RESPONSIBLE PROVIDERS:

A Northwestern Ontario Qualitative Case Study

Interviews via Zoom, in-person or self-recorded!

Fill out the form with your information to participate:

https://bit.ly/3shGT8r

Who's eligible?

LOOKING FOR:

Students currently enrolled at least part-time in one of the following programs:

- Nursing
- Medicine

*Must have completed at least one academic term within your program prior to participating, preference given to those who are upperclassmen.

***This study has been reviewed by Lakehead University's REB #1469388 and Confederation College's REB #0108**

Appendix D

Recruitment Form for Prospective Participants

Participant Recruitment: Student Perspectives on Preparation to be Socially Accountable Providers: A Northwestern Ontario Qualitative Case Study

If you are interested in participating in an individual interview to discuss your experience within your program of study, please input your information below. The Primary Investigator of this project, Alexis Harvey, will be reaching out to you. Should you have any questions prior to being contacted, you can email: aharvey5@lakeheadu.ca

* Required

Name *

Your answer

Preferred pronouns *

- [ ] She/her
- [ ] They/them
- [ ] He/him
- [ ] Other:

Preferred email *

Your answer

Where are you a student? *

- ◯ Confederation College
- ◯ Lakehead University
- ◯ Northern Ontario School of Medicine

Program of study *

- ☐ Nursing (BScN) or Practical Nursing
- ☐ Paramedicine
- ☐ Medicine (MD)

Current year in school: *

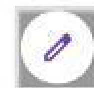
Your answer

Submit Clear form

Never submit passwords through Google Forms.

This form was created inside of Lakehead University. Report Abuse

Google Forms



Appendix E

Information Letter

Student Perspectives on Preparation to be Just and Socially Responsible Providers: A northwestern Ontario Qualitative Case Study

Thank you for your interest in this research project. Your time and help are truly appreciated. This sheet gives some basic information on the research, what you can expect, how the data will be handled and used in the future. If anything is unclear or you want more information, please feel free to ask any question you wish, my contact details are at the end of this document.

What is this research about?

This research project is part of the thesis requirement for my Master of Health Sciences. It is looking at the extent to which pre-health profession students feel prepared by their academic training to be socially accountable healthcare providers.

What is being requested of me?

You are being invited to participate in this research because you are a student in a selected pre-health profession program at your institution. I am asking you to participate in a 1-hour interview to share your knowledge and perspectives about **your academic training and its impact on your preparedness to work towards health equity for diverse patient populations.** Your participation is completely voluntary; you may refuse to answer any questions, or withdraw from the study at any time.

Are there any benefits or risks I should be aware of?

Conducting this interview will help me understand **how different pre-professional healthcare programs within northwestern Ontario are preparing future healthcare professionals to be just and socially responsible in working with diverse patient populations, and which practices or student experiences are most important in fostering social justice and social responsibility.** It will also help me create and propose any suggestions to academic programs to improve social responsibility initiatives for pre-health profession programs. Findings from this study may go on to be published in peer-reviewed articles, as well as presented on at conferences, and utilized for program improvement at your academic institutions and institutions. While there are very few perceived risks from participating in this research, I recognize that some questions may be perceived as sensitive, and you may not want certain information made available to myself or potential audience members of this study. Your participation is voluntary and you are only being asked to offer information you feel comfortable sharing with us. Interviews will be audio recorded, with your consent, and anonymized prior to analysis. All data will be stored on a password-protected USB pen drive and stored at Lakehead University for a period of at least 5 years following the completion of the study.

How should I expect to be treated?

This research aims to maintain the highest standards of ethical conduct and integrity. Centrally, this means that in participating in this research you should feel that you, and your contribution to this research, have been treated with respect. Participation is entirely voluntary, and all information offered will be treated in good faith. You are welcome to refuse to participate, withdraw from the research at any time and refuse to answer any of the questions asked without any negative consequences for yourself or your organization. All questions about the research, its aims and outcomes will be answered openly and honestly. While I retain final editorial control over what I choose to write, you are free to withdraw any information you have contributed at any stage by contacting myself and indicating your wish to do so. You will be given the opportunity to review your interview transcript and my interpretations of it once it has been reviewed by myself as the Primary Investigator.

What will happen to the data after it is collected?
In all cases, nothing you say will be attributed to you individually. Your anonymity will always be the number one priority. Only I will have access to the interview transcript and identifiable materials (including audio recordings, hand-written notes and your consent form). All raw data, audio recordings and typing up of interviews will be stored on a password-protected USB pen drive and for up to five years and then destroyed. The final research results will be written into my master's thesis and presented on during my thesis oral defense, the date of which is yet to be set.
Interviews will be conducted via Zoom and as such will be recorded and saved to the same encrypted computer. Following the completion of the thesis, the data will go on to be published as an executive summary of findings and disseminated to relevant program administrators, faculty, or staff at both Lakehead University and Confederation College (for program improvement purposes). Findings may also go on to be published in a peer-reviewed academic journal, as well as presented on at a conference. All data will continue to remain anonymized throughout the publication process. Those who have indicated interest in participating in the study will be emailed regarding how to access the findings following the completion of the study.

For in-person interviews
For research participants electing in-person interviews, please be advised that due to the ongoing COVID-19 pandemic, extra precautions will be taken. This means that the walking interview will be conducted one-on-one and face masks will be required to be worn by both the research participant and the investigator. Exceptions to these rules will not be made unless proof of exemption from masking is shown.

If you have further questions about these processes or feel uncomfortable with any aspect of them, please let me know as soon as possible.

Thank you again for your time and assistance,

Alexis Harvey, aharvey5@lakeheadu.ca

Other Contacts:

Dr. Helle Møller (Thesis Supervisor), hmoeller@lakeheadu.ca

This study has been approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Appendix F

Recruitment Email Text for Lakehead University Departmental Coordinators

Student Perspectives on Preparation to be Just and Socially Responsible Healthcare Providers: A northwestern Ontario Qualitative Case Study

Dear Coordinator/Administrator,

As a master's student at Lakehead University, I will be conducting interviews with students from your program on their **academic training and its impact on preparedness to work towards health equity for diverse patient populations.** I am requesting that you email students within your program the following excerpt and attached flyer so that they can participate should they so choose:

"Dear potential research participants,
As a master's student at Lakehead University, I will be conducting interviews with students from your program on **your academic training and its impact on your preparedness to work towards health equity for diverse patient populations.** This research seeks to **understand a variety of educational and personal factors that may lead future healthcare professionals to actively incorporate social justice and social responsibility into their practice (i.e. Cultural Safety, Social Determinants of Health, Critical Reflection)**. This research is reflective in nature and will ask you to reflect on your academic formation in your current program of study. More specifically, this study will look into what coursework you completed related to social justice and social responsibility in healthcare and whether you feel this has contributed to your preparedness to work with diverse populations towards health equity.

As part of this research, I am seeking students to participate in individual interviews via Zoom. Your identity would remain confidential in any results and your participation is completely voluntary. **Participants will need to meet the following criteria:**

- be a student in one of the following programs: Nursing or Medicine;
- speak English;
- be enrolled at least part-time in your program;
- have been in your current program of study for at least 1 academic term;
- **have taken a course or completed a practical course related to social justice and social responsibility (covering topics such as Cultural Safety, Social Determinants of Health, Indigenous health, etc.)

**indicates preferred but not required criterion.

If you are interested in participating, please contact me at **aharvey5@lakeheadu.ca**

Sincerely,

Alexis Harvey"

Appendix G

Recruitment Email Text for Confederation College Program Coordinators

Student Perspectives on Preparation to be Just and Socially Responsible Healthcare Providers: A northwestern Ontario Qualitative Case Study

Dear Program Coordinator,

As a master's student at Lakehead University, I will be conducting interviews with students from your program on their **academic training and its impact on preparedness to work towards health equity for diverse patient populations.** I am requesting that you email students within your program the following excerpt and attached flyer so that they can participate should they so choose:

"Dear potential research participants,
As a master's student at Lakehead University, I will be conducting interviews with students from your program on **your academic training and its impact on your preparedness to work towards health equity for diverse patient populations.** This research seeks to **understand a variety of educational and personal factors that may lead future healthcare professionals to actively incorporate social justice and social responsibility into their practice (i.e. Cultural Safety, Social Determinants of Health, Critical Reflection)**. This research is reflective in nature and will ask you to reflect on your academic formation in your current program of study. More specifically, this study will look into what coursework you completed related to social justice and social responsibility in healthcare and whether you feel this has contributed to your preparedness to work with diverse populations towards health equity.

As part of this research, I am seeking students to participate in individual interviews via Zoom. Your identity would remain confidential in any results and your participation is completely voluntary. **Participants will need to meet the following criteria:**

- be a student in one of the following programs: Paramedicine, Practical Nursing, or Collaborative (BSc) Nursing
- speak English;
- be enrolled at least part-time in your program;
- have been in your current program of study for at least 1 academic term;
- **have taken a course or completed a practical course related to social justice and social responsibility (covering topics such as Cultural Safety, Social Determinants of Health, Indigenous health, etc.)

**indicates preferred but not required criterion.

If you are interested in participating, please contact me at **aharvey5@lakeheadu.ca**

Sincerely,

Alexis Harvey"

Appendix H

Recruitment Email Text for Faculty within Target Programs at Confederation College

Student Perspectives on Preparation to be Just and Socially Responsible Healthcare Providers: A northwestern Ontario Qualitative Case Study

Dear Faculty Member,

As a master's student at Lakehead University, I will be conducting interviews with students from your department on their **academic training and its impact on preparedness to work towards health equity for diverse patient populations.** I am requesting that you email students within your courses the following excerpt (in quotation marks) and attached flyer so that they can participate should they so choose. Additionally, you may reach out to me directly at the email below should you wish for me to talk about the study briefly in your course(s).

"Dear potential research participants,
As a master's student at Lakehead University, I will be conducting interviews with students from your program on **your academic training and its impact on your preparedness to work towards health equity for diverse patient populations.** This research seeks to **understand a variety of educational and personal factors that may lead future healthcare professionals to actively incorporate social justice and social responsibility into their practice (i.e. Cultural Safety, Social Determinants of Health, Critical Reflection)**. This research is reflective in nature and will ask you to reflect on your academic formation in your current program of study. More specifically, this study will look into what coursework you completed related to social justice and social responsibility in healthcare and whether you feel this has contributed to your preparedness to work with diverse populations towards health equity.

As part of this research, I am seeking students to participate in individual interviews via Zoom. Your identity would remain confidential in any results and your participation is completely voluntary. **Participants will need to meet the following criteria:**

- be a student in one of the following programs: Paramedicine, Practical Nursing, Collaborative (BSc) Nursing
- speak English;
- be enrolled at least part-time in your program;
- have been in your current program of study for at least 1 academic term;
- **have taken a course or completed a practical course related to social justice and social responsibility (covering topics such as Cultural Safety, Social Determinants of Health, Indigenous health, etc.)

**indicates preferred but not required criterion.

If you are interested in participating, please contact me at **aharvey5@lakeheadu.ca**

Sincerely,
Alexis Harvey"

Appendix I

Recruitment Email Text for Faculty within Target Programs at Lakehead University

Student Perspectives on Preparation to be Just and Socially Responsible Providers: A northwestern Ontario Qualitative Case Study

Dear Faculty Member,

As a master's student at Lakehead University, I will be conducting interviews with students from your department on their **academic training and its impact on preparedness to work towards health equity for diverse patient populations.** I am requesting that you email students within your courses the following excerpt (in quotation marks) and attached flyer so that they can participate should they so choose. Additionally, you may reach out to me directly at the email below should you wish for me to talk about the study briefly in your course(s).

"Dear potential research participants,
As a master's student at Lakehead University, I will be conducting interviews with students from your program on **your academic training and its impact on your preparedness to work towards health equity for diverse patient populations.** This research seeks to **understand a variety of educational and personal factors that may lead future healthcare professionals to actively incorporate social justice and social responsibility into their practice (i.e. Cultural Safety, Social Determinants of Health, Critical Reflection)**. This research is reflective in nature and will ask you to reflect on your academic formation in your current program of study. More specifically, this study will look into what coursework you completed related to social accountability in healthcare and whether you feel this has contributed to your preparedness to work with diverse populations towards health equity.

As part of this research, I am seeking students to participate in individual interviews via Zoom. Your identity would remain confidential in any results and your participation is completely voluntary. **Participants will need to meet the following criteria:**

- be a student in one of the following programs: Nursing or Medicine;
- speak English;
- be enrolled at least part-time in your program;
- have been in your current program of study for at least 1 academic term;
- **have taken a course or completed a practical course related to social justice and social responsibility (covering topics such as Cultural Safety, Social Determinants of Health, Indigenous health, etc.)

**indicates preferred but not required criterion.

If you are interested in participating, please contact me at **aharvey5@lakeheadu.ca**

Sincerely,
Alexis Harvey"

Appendix J

Interview Guide

Interview Protocol: Student Perspectives on Preparation to be Just and Socially Responsible Providers: A northwestern Ontario Qualitative Case Study
Time:
Date:
Place:
Interviewer:
Interviewee:
Program of Interviewee:

Checklist (Zoom):

- **Describe project (use information letter bolded information), emphasize ability to withdraw at any time, access to data, and anonymization of data**
- **Indicate to turn on camera if able and consent given**
- **Reiterate that signing the consent form indicates agreeing to having the meeting recorded and saved to a removable, password-protected USB pen drive**
- **Sign consent letter and send to me (via email prior to commencing with questions)**
- **RECORD MEETING (if consent provided)**
- **Introduce self and establish position**

Checklist (walking interview):

- **Describe project (use information letter bolded information), emphasize ability to withdraw at any time, access to data, and anonymization of data**
- **Place audio recording devices on person and ensure they are functioning properly**
- **Reiterate that signing the consent form indicates agreeing to having the meeting audio-recorded and saved to a removable, password-protected USB pen drive**
- **Sign consent letter**
- **BEGIN AUDIO RECORDING (if consent provided)**
- **Introduce self and establish position**

The following are the developed guiding research questions, with sub-questions related to each broader question to help facilitate conversation-like flow, indicated by italic font, and further questions within each category enumerated by letters.

1. Tell me about yourself.
    a. What is your current program of study?

  b. What program are you currently enrolled in (*What degree or level of certification are you seeking? When are you intending to graduate)?*

2. How do you identify or what would you consider to be your strongest identities? *(This can be, but is not limited to, gender, sexual orientation, occupation, ethnicity, race, religion, nationality, parenting status, or health status.)*
    a. *What is your gender identity, and do you have preferred pronouns?*
    b. *What is your ethnic identity?*
    c. *Do you hold any titles or degrees not mentioned in response to the previous question?*
    d. *Are you involved in any clubs?*
    e. *Are you involved in any community or volunteer organizations, or movements? (i.e. advocacy work, community organizing, passion projects)*
3. For your chosen line of work, what do you consider to be the main priorities and responsibilities of that occupation?
4. What do you consider to be involved in working towards health equity?
    a. Can you give me an example of what this might look like? *(i.e. an initiative you have seen regarding Social Accountability or a scenario of what it might look like in practice)*
5. Within your current program of study, have you taken courses that touched on any of the following concepts: Cultural Safety, Competency, or Humility; Social Determinants of Health; health advocacy; anti-racism; anti-colonialism; intersectionality; or White privilege?

a. Did the course(s) touch on specific patient populations? *(For example, Indigenous peoples, homeless populations, mothers and children, dis/abled peoples, LGBTQIA2S+, immigrants and refugees, etc.)*

b. Without disclosing a name, can you tell me about the person who taught this course? *(What was their relation to the faculty, discipline, or topic? Did the course employ guest speakers, lecturers, or presenters?)*

c. Was/were the course(s) compulsory for your program or (an) elective course(s)?

d. In the course, did you touch on advocacy? *(If so, what was discussed in relation to this topic?)*

e. Was there any practical or experiential learning component? *(Did you work on a community-based project or engage with community members to aid your learning?)*

f. Was there any sort of knowledge tests in this/these course(s)? *(Did you have exams, projects, write ups, reflection pieces, or other assignments that required you to synthesize what you had learned and apply it?)*

g. Was/were this/these course(s) lecture or discussion based?

h. Do you have any memories that stand out to you from your time in this/these class(es)? *(These can be good or bad, critiques, memorable moments, etc.; Can you give examples?)*

6. During your time in your current program, have you done any practical learning within the community? *(This can be clinical placements, practicums, or related to specific courses)*

a. How long was your placement and how frequently were you there? Did you find this sufficient to learn the intended curriculum?

b. Were you able to link concepts you learned about working with diverse populations with your work *(Cultural Safety, SDOH, etc.)*?

c. Did you find that the material you learned in class was being acted on in practice by other healthcare professionals? *(i.e. Cultural Safety was being employed by preceptor during clinical placement, Social Determinants of Health were considered during placement, etc.)*

d. Do you recall if there was a course outline for this placement that listed the expected learning outcomes? *(This is usually a description that would be sent to the organizations where you participate in these experiential learning courses)*

7. Can you provide an example of a time you were able to apply concepts related to creating health equity in real life (knowledge of SDOH, Cultural Safety/Humility, Social Justice)? Alternatively, can you provide an example of a time you wish you had more knowledge in this area? *(if the latter, ask whether this was recent or prior to enrolment in current program)*

8. How do you define health equity?

   a. Do you feel that you have a role in working towards health equity?

   b. Do you feel that you have a role in addressing the Social Determinants of Health? *(What exactly does this look like for you in your role?)*

9. Are there any concepts related to working towards health equity that you wish were included in your current program of study? *(Indigenous health, remote healthcare, Cultural Safety, Social Determinants of Health, challenging personal biases, etc.)*

10. Do you feel that your academic training will have adequately prepared you to work with people of diverse backgrounds? *(this includes people of different races, cultures, ethnicities, abilities, religions, socioeconomic statuses, genders, sexual orientations, etc.)*
11. Is there anything else that we have not covered that you would like to mention?
12. Is there anyone else that you think I should interview for this project? *(Name and email)*

Thank you so much for your time. I will be in contact with you once your interview has been analyzed so that you can review your interview transcript and my notes and interpretation of what you have shared. This is to ensure that your insight is represented and interpreted adequately to reflect your experience that you have shared here today.

Appendix K

Recruitment Email Text for Participants Recruited via Snowball Sampling

Student Perspectives on Preparation to be Just and Socially Responsible Healthcare Providers: A northwestern Ontario Qualitative Case Study

Dear Potential Participant,

As a master's student at Lakehead University, I am currently conducting interviews with students from your program on their **academic training and its impact on preparedness to work towards health equity for diverse patient populations.**

You were mentioned as someone who may potentially be interested in participating in this project. This research seeks to **understand a variety of educational and personal factors that may lead future healthcare professionals to actively incorporate social justice and social responsibility concepts into their practice (i.e. Cultural Safety, Social Determinants of Health, Critical Reflection)**. This research is reflective in nature and will ask you to reflect on your academic formation in your current program of study. More specifically, this study will look into what coursework you completed related to social justice and social responsibility in healthcare and whether you feel this has contributed to your preparedness to work with diverse populations towards health equity.

As part of this research, I am seeking students to participate in individual interviews via Zoom. Your identity would remain confidential in any results and your participation is completely voluntary. **Participants will need to meet the following criteria:**

- be a student in one of the following programs at Confederation College: Paramedicine, Practical Nursing, Collaborative (BSc) Nursing
  OR
  Be a student in one of the following programs at Lakehead University: Nursing, Medicine;
- speak English;
- be enrolled at least part-time in your program;
- have been in your current program of study for at least 1 academic term;
- **have taken a course or completed a practical course related to social justice and social responsibility (covering topics such as Cultural Safety, Social Determinants of Health, Indigenous health, etc.)

**indicates preferred but not required criterion.

If you are interested in participating, please contact me at **aharvey5@lakeheadu.ca**

Sincerely,

Alexis Harvey

Appendix L
Research Participant Consent Form

Participant Consent Form

Please check each statement to confirm you have read and understand all of the terms of your participation in this research.

* Required

1. Name (First, Last) *

2. I have discussed the details of this research project and agree to participate in the research. *

   Check all that apply.

   ☐ yes

3. I have had the opportunity to ask any questions I had regarding my participation in the research. *

   Check all that apply.

   ☐ Yes

4. I understand that the purpose of the research is to assess pre-health profession students' experiences with academic training and the impact this has had in preparing them to be socially accountable healthcare providers. *

   Check all that apply.

   ☐ yes

5. I understand that my participation in this study is voluntary and that I may withdraw at any time for any reason without penalty. *

Check all that apply.

- [ ] Yes

6. I understand that there is no obligation to answer any questions that I feel are invasive, offensive or inappropriate. *

Check all that apply.

- [ ] Yes

7. Unless explicitly agreed to otherwise, I understand that information I provide will never be attributed to myself individually. *

Check all that apply.

- [ ] Yes

8. I understand I may ask questions of the researcher at any point during the research process. *

Check all that apply.

- [ ] Yes

9. I understand that there are risks of contracting COVID-19 during in-person research *

Check all that apply.

- [ ] Yes

10. I understand that the results of this study will be shared with the public in the form of a master's thesis, published articles, conference presentation(s), and an executive summary of findings. *

The 'public' includes but is not limited to: educators within your academic program(s); university/college administrators/faculty/staff at your institution or other institutions; conference attendees at which this study may be presented; etc.

Check all that apply.

☐ Yes

11. I understand that I will be given the option to review my interview transcript following transcription and review by the Primary Investigator, Alexis Harvey. *

Check all that apply.

☐ Yes

12. I agree to have this interview video and audio recorded. *

The interview will be recorded and saved from Zoom to the Primary Investigator's password-protected computer.

Mark only one oval.

◯ Yes

◯ No

◯ Other: ______________________

13. Would you like to receive a copy of the research results? *

Mark only one oval.

◯ Yes

◯ No

14. I am fully aware of the nature and extent of my participation in this project as stated above. *

Please type in your full name.

____

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Appendix M

Interview Guide for Self-Recorded Responses

Interview Protocol: Student Perspectives on Preparation to be Just and Socially Responsible Providers: A northwestern Ontario Qualitative Case Study

Checklist (self-recorded interview):

- **Read the information letter provided to you via email**
- **Complete the consent form (Google Form) that was provided to you via email**
- **Clarify any questions or concerns you have regarding the study with the Primary Investigator, Alexis Harvey prior to beginning your recording: aharvey5@lakeheadu.ca**
- **Begin audio recording yourself or using talk-to-text software to record your responses to the following questions**
- ***Once you are done: save your audio recording and name it with the date you conducted your recording (i.e. "Nov122022"), and send to aharvey5@lakeheadu.ca***

When responding to these questions, please note that while they may ask for one example, you are encouraged to provide as many examples or talk about multiple instances that relate to the questions.

The following are the developed guiding research questions, with sub-questions related to each broader question to help facilitate conversation-like flow, indicated by italic font, and further questions within each category enumerated by letters.

13. Tell me about yourself.
    a. What is your current program of study?
    b. What program are you currently enrolled in (*What degree or level of certification are you seeking? When are you intending to graduate)?*
14. How do you identify or what would you consider to be your strongest identities? *(This can be, but is not limited to, gender, sexual orientation, occupation, ethnicity, race, religion, nationality, parenting status, or health status.)*
    a. *What is your gender identity, and do you have preferred pronouns?*
    b. *What is your ethnic identity?*

c. *Do you hold any titles or degrees not mentioned in response to the previous question?*

d. *Are you involved in any clubs?*

e. *Are you involved in any community or volunteer organizations, or movements? (i.e. advocacy work, community organizing, passion projects)*

15. For your chosen line of work, what do you consider to be the main priorities and responsibilities of that occupation?

16. What do you consider to be involved in working towards health equity?

    a. Can you give me an example of what this might look like? *(i.e. an initiative you have seen regarding Social Justice or Social Responsibility or a scenario of what it might look like in practice, as it relates to healthcare)*

17. Within your current program of study, have you taken courses that touched on any of the following concepts: Cultural Safety, Competency, or Humility; Social Determinants of Health; health advocacy; anti-racism; anti-colonialism; intersectionality; or White privilege?

    a. Did the course(s) touch on specific patient populations? *(For example, Indigenous peoples, homeless populations, mothers and children, dis/abled peoples, LGBTQIA2S+, immigrants and refugees, etc.)*

    b. Without disclosing a name, can you tell me about the person who taught this course? *(What was their relation to the faculty, discipline, or topic? Did the course employ guest speakers, lecturers, or presenters?)*

    c. Was/were the course(s) compulsory for your program or (an) elective course(s)?

d. In the course, did you touch on advocacy? *(If so, what was discussed in relation to this topic?)*

e. Was there any practical or experiential learning component? *(Did you work on a community-based project or engage with community members to aid your learning?)*

f. Was there any sort of knowledge tests in this/these course(s)? *(Did you have exams, projects, write ups, reflection pieces, or other assignments that required you to synthesize what you had learned and apply it?)*

g. Was/were this/these course(s) lecture or discussion based?

h. Do you have any memories that stand out to you from your time in this/these class(es)? *(These can be good or bad, critiques, memorable moments, etc.; Can you give examples?)*

18. During your time in your current program, have you done any practical learning within the community? *(This can be clinical placements, practicums, or related to specific courses)*

    a. How long was your placement and how frequently were you there? Did you find this sufficient to learn the intended curriculum?

    b. Were you able to link concepts you learned about working with diverse populations with your work *(Cultural Safety, SDOH, etc.)*?

    c. Did you find that the material you learned in class relating to just and socially-responsible care was being acted on in practice by other healthcare professionals? *(i.e. Cultural Safety was being employed by preceptor during clinical placement, Social Determinants of Health were considered during placement, etc.)*

   d. Do you recall if there was a course outline for this placement that listed the expected learning outcomes? *(This is usually a description that would be sent to the organizations where you participate in these experiential learning courses)*

19. Can you provide an example of a time you were able to apply concepts related to creating health equity in real life (knowledge of SDOH, Cultural Safety/Humility, Social Justice)? Alternatively, can you provide an example of a time you wish you had more knowledge in this area? *(if the latter, was this recent or prior to enrolment in current program?)*
20. How do you define health equity?
    a. Do you feel that you have a role in working towards health equity?
    b. Do you feel that you have a role in addressing the Social Determinants of Health? *(What exactly does this look like for you in your role?)*
21. Are there any concepts related to working towards health equity that you wish were included in your current program of study? *(Indigenous health, remote healthcare, Cultural Safety, Social Determinants of Health, challenging personal biases, etc.)*
22. Do you feel that your academic training will have adequately prepared you to work with people of diverse backgrounds? *(this includes people of different races, cultures, ethnicities, abilities, religions, socioeconomic statuses, genders, sexual orientations, etc.)*
23. Is there anything else that has been not covered that you would like to mention?
24. Is there anyone else that you think should be interviewed for this project? *(Please provide their name and email or email aharvey5@lakeheadu.ca directly to connect us!)*

Thank you so much for your time. I will be in contact with you once your interview has been analyzed so that you can review your interview transcript and my notes and interpretation of what you have shared. This is to ensure that your insight is represented and interpreted adequately to reflect your experience that you have shared here today.

Appendix N

Executive Summary

The problem:

While social accountability (SA) has taken over the undergraduate medical education (UME) scene as a means to work towards community-centred health equity, there is yet to be seen such an predominant model for other areas of health professions education. Additionally, literature relevant to such movements in education centers predominantly around UME. To better prepare health professions students to work towards health equity through a lens of social responsibility and justice, more work is needed to understand current knowledge and knowledge gaps. This study sought to answer the question: how do health professions students feel that their education has adequately informed, prepared, and encouraged them to work as a just and socially responsible healthcare provider? To do this, a qualitative multiple case study conducted at two institutions: Lakehead University (LU) and Confederation College (CC) in Thunder Bay, Ontario was completed. Within the Lakehead University case, the Compressed and Collaborative bachelor of science in nursing (BScN) program, as well as the UME program (now a separate institution known as the Northern Ontario School of Medicine University) were analyzed. From Confederation College, the Collaborative BScN, Practical Nursing, and Primary Care Paramedicine programs were analyzed. Questions centred around student identities, instructor identities, curricular concepts covered, pedagogical style, and clinical placement experiences.

The findings:

Students reported a mixture of preparation and needs after reflecting on the time in their programs. Most students reported feeling prepared (10 out of 11 from the CC case and 11 out of 13 from the LU case). However, many pointed to a combination of personal background and

lived experience in addition to their education as having prepared them to work towards health equity in a just and socially responsible manner, often relaying that time in their academic program alone would not have prepared them.

For the CC case, themes from the data are as follows:

1. *Preparation is a patchwork*
2. *Inherent (de)valuing of just and socially responsible care concepts*
3. *Contextualizing the curriculum to place*
4. *Superficiality*
5. *Varied didactic styles, varied outcomes*
6. *Instructor identities influence learning*

For the LU case the themes from the data are as follows:

1. *Preparation is a patchwork*
2. *The theory to practice gap*
3. *(Un)supportive learning environment*
4. *Contextualizing the curriculum to place and practice*
5. *Superficiality*
6. *Front loading of didactic material*
7. *Instructor identities influence learning*

The considerations:

After conducting interviews and environmental scans online of both cases and the programs therein, and reviewing the literature, these are the following considerations:

For the CC case:

1. *Valuing these concepts in practice*.
    a. While concepts such as intercultural competency and Indigenous curriculum are highlighted in CC's guiding documents, there is a need to revise some of the praxis behind these goals. This might best be done through a revised grading scheme for courses that touch on these topics (e.g. the course *Human Diversity*). Additionally, integrating concepts in a way that is perceptively meaningful and intentional into courses throughout the length of programs may also relay their value and importance to providing equitable patient care (also seen in Beavis et al., 2015). This has been mandated with Indigenous health concepts throughout the institution as noted within the literature review. However, continuing on this trend with other important concepts such as CS, intersectionality, and critical consciousness may help promote SRSJ within the student body.
2. *Increasing students' exposure to just and socially responsible care concepts*.
    a. This can be done by incorporating these concepts more frequently into lessons and including them as learning objectives for clinical placements and clinical debriefing activities. Furthermore, concepts should be expanded upon instead of briefly touched on, and lessons should focus on the practicality of these concepts in working towards health equity (e.g. applying intersectionality or cultural safety to understanding power dynamics in the clinical setting).
3. *Establishing a commitment to promoting just and socially responsible practice.*
    a. This may be by way of mandates, mission statements and policies supporting inclusion of these concepts. Such mandates and policies should be directed at curriculum as well as recruitment efforts for both students and staff (i.e.

promoting diversity within the classroom and representation from various backgrounds). Recruiting staff and students of various backgrounds into targeted programs (i.e. professions, educational backgrounds, ethnicities, ages, etc.) will serve to bolster the acquisition of concepts as evidenced by this work and other literature (Dickson & Manalo, 2014). While the strategic plan has focused on recruitment and diversification as well as supporting the inclusion of global citizenship and Indigenous health related curricula, it may be beneficial to continuously monitor these efforts and the outcomes as a result of such efforts to inform next steps and other potential concepts to promote that continue to further the promotion of SRSJ among students.

For the LU case:

1. *Committing to promoting just and socially responsible practice particularly within the health professions.*
    a. This can be done through implementing program-level mandates and mission statements, and defining programmatic goals with strategic plans specifically for health professions programming (as can be seen with the UME program). While strategic planning that includes the importance of social responsibility and community engagement is in place for the institution as a whole, additional considerations and academic planning may be beneficial for programs such as undergraduate nursing.
2. *Establishing space and systems of support.*
    a. This is specifically aimed at supporting students who report instances of unsafe and unethical patient encounters or instances of discriminatory or derogatory

application of these concepts (e.g. hyper-focus on Indigenous health curriculum that is deficits-based). This may look different depending on the program and stage in which students find themselves (i.e. pre-clinical or clinical placements). However, establishing a space and (potentially anonymous) process for handling complaints against the institution or its various components (programs, instructors, partners, etc.) may help students feel safe to voice their concerns as well as to be supported in acting on concepts of social justice and social responsibility while still classified as a learner. While formal complaint processes are in place for violating university violations, it may be difficult to reconcile the complaint of microaggressions and hidden curriculum. More research should look into this.

3. *Diversifying the learning environments*.
    a. This consideration comes from student reports of faculty and instructors lacking perceived cultural or ethnic diversity. Additionally, participants pointed to enhanced engagement when their fellow students had diverse backgrounds and life experience to help promote dialogue around just and socially responsible care concepts (this has been reported elsewhere as well: Dickson & Manalo, 2014). While these diversification intentions are a part of the strategic plan mentioned in the literature review, continued efforts to work towards increased diversity may be warranted. In addition to recruitment of diverse instructors and students, further and explicit promoting of the option for non-traditional clinical placements for students (e.g. rural placements and public health placements) may help the

acquisition of such concepts (i.e. further engaging students in place-based curriculum) (see for examples: Abbott et al.,. 2020; Kaufman et al., 1979).

4. *Evaluating distributed learning models*.
    a. While both of the programs within this case (BScN and UME) utilized some form of distributed learning (e.g. community-based BScN, rural clinical placements for UME learners), there are various reports of students feeling as though the concepts learned in the classroom are not being fully supported in these distance-based settings or that they are unable to connect the dots in placement between theory and practice. This points to a potential lack of consistency between the classroom and community placement partners. The institution should assess gaps in the support offered by community partner organizations and opportunities (i.e. community placements, clinicals, etc.) that may help students hone their just and socially responsible care concepts when not located directly on campus. This may look something like weekly debriefs with the main academic institution (e.g. BScN faculty on campus via Zoom), or potentially requiring facilitators on the ground who are committed to just and socially responsible care who can act as support for students. Additionally, ongoing evaluation and monitoring of these supports and their impact should be incorporated.

The value:

Healthcare providers within northwestern Ontario service a diverse population over a geographic expanse of 526,478.23 square kilometers (Statistics Canada, 2016). This often leads to professional isolation and lack of resources. Such a setting requires capable and competent healthcare providers who are fully informed, prepared, and encouraged to provide just and

socially responsible care. Ensuring academic institutions and their health professions programs are set up to not only inform students of best practice, but to prepare and encourage them to use it is essential. This work provides suggestions on how to ensure such groundwork is completed so that students' learning outcomes can be bolstered, and ultimately health outcomes improved across the region.

References:

Boelen, C. (2000). *Challenges and opportunities for partnership in health development*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/66566/WHO_EIP_OSD_2000.9.pdf?sequence=1&isAllowed=y

Statistics Canada. (2016). *Census profile, 2016 census Northwest [economic region],Ontario and Ontario [province]*. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Northwest&SearchType=Begins&SearchPR=01&TABID=1&G=1&Geo1=ER&Code1=3595&Geo2=PR&Code2=35&type=0&B1=Immigration%20and%20citizenship

Appendix O

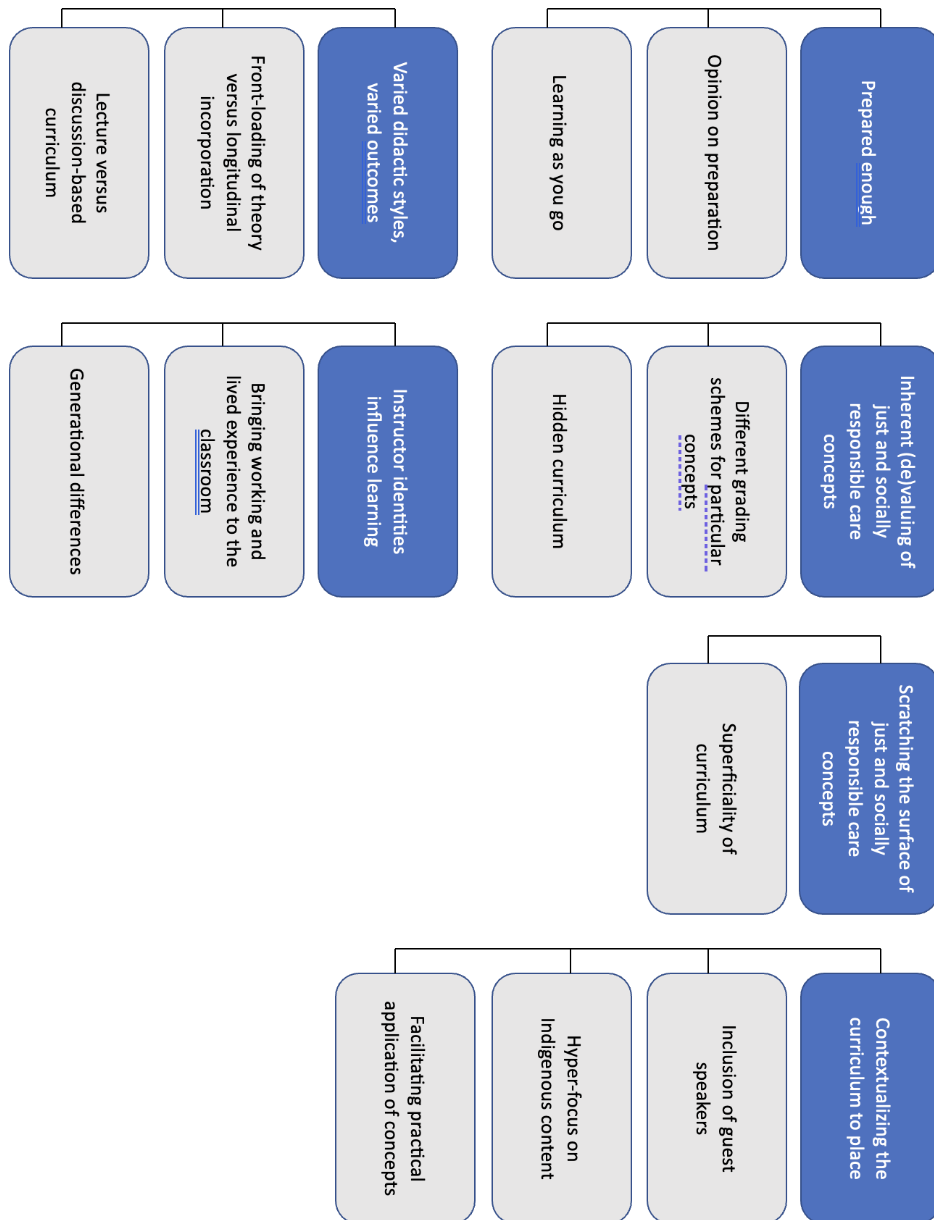
Boelen's Expanded Social Accountability Grid (2000)

VALUES	DOMAINS AND PHASES								
	Education			Research			Service		
	Planning	Doing	Impacting	Planning	Doing	Impacting	Planning	Doing	Impacting
Quality									
Equity									
Relevance									
Cost-Effectiveness									

Figure 6 is adapted from this grid originally envisioned by Boelen (2000) to evaluate social accountability of academic institutions.

Appendix P

Confederation College Case Themes and Subthemes



Appendix Q

Lakehead University Case Themes and Subthemes