

**NURSING THE '*OTHER*':
EXPLORING THE ROLES AND CHALLENGES OF NURSES WORKING WITHIN
RURAL, REMOTE, AND NORTHERN CANADIAN ABORIGINAL COMMUNITIES**

ZAIDA RAHAMAN, RN, BScN, MN, PhD(c)

Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements
for the Doctorate in Philosophy degree in Nursing

School of Nursing
Faculty of Health Sciences
University of Ottawa

© Zaida Rahaman, Ottawa, Canada, 2014

***Keep me away from the wisdom, which does not cry,
the philosophy which does not laugh, and the greatness which
does not bow before children.***

- Khalil Gibran

Table of Contents

LIST OF FIGURES	vii
LIST OF TABLES	viii
ABSTRACT	ix
ACKNOWLEDGEMENTS	xi
INTRODUCTION	1
1. RESEARCH PROBLEM	5
1.1 RESEARCH PROBLEM.	5
1.1.1 Nursing Situations	6
1.1.2 Environmental Site and Scan	8
1.2 RESEARCH OBJECTIVES... ..	11
1.3 RESEARCH QUESTIONS	11
1.4 EPISTEMIC STANCE	12
2. LITERATURE REVIEW	16
2.1 BEYOND HEALTHY PUBLIC POLICIES	16
2.1.1 Responses and Reactions	18
2.2 FRONTLINE HEALTH DIALOGUE	20
2.2.1 Critical Thoughts	21
2.2.2 Federal Stakeholders' Interest	24
2.3 ABORIGINAL HEALTH	28
2.3.1 Canadian Demographics	28
2.3.2 State Health Affairs	29
<i>Health Inequities</i>	30
<i>Social Determinants of Health</i>	31
2.4 PRIMARY HEALTH CARE	33
2.4.1 Overview and Principles	33
2.4.2 Chronic Disease Management	37
2.5 NORTHERN NURSING PRACTICE	40
2.5.1 Racialization of Health Care System Delivery	41
2.5.2. Profiles in Practice	44
<i>Nursing Roles</i>	44
<i>Nursing Challenges</i>	46

3. THEORETICAL FRAMEWORK.....	50
3.1 POSTCOLONIAL THEORY	52
3.1.1 Influencing the Nursing Profession.....	52
3.1.2 Nursing Knowledge Development.....	53
3.1.3 Paradigms	54
<i>Application</i>	56
<i>Safeguarding Vulnerable Populations</i>	58
3.2 FRANTZ FANON.....	61
3.2.1 Race Theory	61
<i>Colonial Relations and Colonial Practices</i>	61
<i>Race and Economics</i>	63
3.2.2 Race Construction.....	67
<i>The 'Other'</i>	67
<i>Violence</i>	68
<i>'Othering'</i>	70
3.3 JULIA KRISTEVA	71
3.3.1 Semiotics and Symbolic	71
3.3.2 Abjection.....	73
<i>The Subjectified Self</i>	74
3.4 MICHEL FOUCAULT	77
3.4.1 Challenging the Status Quo	78
3.4.2 Power/Knowledge	79
3.4.3 Bio-power	83
<i>Power over Life.</i>	83
<i>Ruling 'Race' Relations</i>	84
3.5 INTEGRATION OF THEORETICAL PERSPECTIVES.....	88
4. METHODOLOGICAL CONSIDERATIONS	90
4.1 QUALITATIVE RESEARCH.....	91
4.2 CRITICAL DISCOURSE ANALYSIS.....	94
4.2.1 Marginalized Populations.....	95
4.2.2 Relationship-based: Social Practices and Language	96
4.2.3 Critical Goals	98
4.3 RESEARCH SETTINGS AND RECRUITMENT.....	101
4.3.1 Contextual Description	102
4.3.2 Local Context	107
4.4 DATA COLLECTION	109
4.5 DATA ANALYSIS.....	110
4.6 ETHICAL CONSIDERATIONS.....	112
4.6.1 Rigour.....	113

5. RESULTS	116
5.1. Structural Health Care Systems	117
5.1.1 Organizational Culture	119
5.1.2 Carrying Capacity	129
5.1.3 Administrative Influence.....	144
5.2. Public Portrayal of: 'Native' Peoples.....	153
5.2.1 By Nurses	154
5.2.2 By Stakeholders	162
5.3. 'Native' Communities.....	167
5.3.1 By Nurses.....	167
5.3.2 By Stakeholders	174
5.4. Colonizing Nursing Practice	179
5.4.1 Public Health Surveillance.....	180
1965.4.2 Gate Keeping.....	190
5.4.3 Health Education.....	196
5.5. Mobilizing Pathways in Aboriginal Health	201
5.5.1 Reflections	202
5.5.2 Community Health Capacity	208
5.3.3 Call to Action.....	214
5.6 RÉSUMÉ	221
6. DISCUSSION	225
6.1 Major Findings	226
6.1.1 The Colonial Nurse-client Relationship.....	227
6.1.2 The 'Aboriginal' Construct	235
6.1.3 Protecting the Segregated State	241
6.2 IMPLICATIONS.....	250
6.2.1 Practice	250
6.2.2 Research	253
6.2.3 Education	254
6.3 LIMITATIONS.....	255
CONCLUSION	259
REFERENCES	264
APPENDIX A. SEMI-STRUCTURED INTERVIEW GUIDE	292
APPENDIX B. ETHICS APPROVAL CERTIFICATE.....	293
APPENDIX C. CONSENT FORM	294

APPENDIX D. DEMOGRAPHIC QUESTIONNAIRE	298
APPENDIX E. DEMOGRAPHIC RESULTS	299

List of Figures

FIGURE 1.1: SUMMARY OF MAJOR THEMES	117
FIGURE 1.2: INTERVIEW THEMES AND SUB-THEMES	118
FIGURE 2.1: MAJOR FINDINGS	227

List of Tables

TABLE E.1.1: DEMOGRAPHIC INFORMATION	299
TABLE E.1.2: COMMUNITY-BASED PROGRAMS [RURAL AND REMOTE].....	300

Abstract

State dependency and the lingering impacts of colonialism dancing with Aboriginal peoples are known realities across the Canadian health care landscape. However, delving into the discourses of how to reduce health disparities of a colonized population is a sophisticated issue with many factors to consider. Specifically, nurses can play a central role in the delivery of essential health services to the '*Other*' within isolated Northern Aboriginal communities. As an extension of the state health care system, nurses have a duty to provide responsive and relevant health care services to Aboriginal peoples.

The conducted qualitative research, influenced by a postcolonial epistemology, sought to explore the roles and challenges of nurses working within rural, remote, and Northern Canadian Aboriginal communities, as well as individual, organizational, and system level factors that supported or impeded nurses' work in helping to meet Aboriginal peoples' health needs with meaningful care. Theorists include the works of Fanon on colonization and racial construction; Kristeva on semiotics and abjection; and Foucault on power/knowledge, governmentality, and bio-power were used in providing a theoretical framework to help enlighten the research study presented within this dissertation.

Critical Discourse Analysis of twenty-five semi-structured interviews with nurses, physicians, and regional health care administrators was deployed to gain a better understanding of the responsibilities and challenges of nurses working in Northern Canada. Specifically, the research study was conducted in one of the three health regions within Northern Saskatchewan. Major findings of this study include: (1) the Aboriginal person did not exist without being in a relation with their colonial agent, the nurse, (2) being

'Aboriginal' was constructed as a source of treating illnesses and managing diseases, and (3) as a collective force, nursing was utilized as means of governmentality and as provisions of care situated within colonial laws.

Historically, nurses functioned as a weapon to 'save' and 'civilize' Aboriginal peoples for purposes of the state. Primarily, present day nursing roles focused on health care duties to promote a decency of the state, followed by missionary tasks. In turn, the findings of this research study indicate that nurses must have a better understanding of the impact of colonialism on Aboriginal peoples' health before they engage with local communities. Knowledge development through postcolonial scholarship in nursing can help nurses and health service providers to strengthen their self-reflective practice, in working towards de-signifying poor discourses around Aboriginal peoples' health and to help create new discourses.

Acknowledgements

Several years ago, I worked as a health policy consultant in rural and remote Northern Saskatchewan. I saw things I should not have seen; I heard things I did not want to hear. With determination, I enrolled in the PhD program in Nursing at the University of Ottawa. Dr. Dave Holmes, Director and Professor with the School of Nursing, and my co-supervisor, Professor Larry Chartrand with the Faculty of Common Law, supported me to achieve my goals towards critical nursing inquiry. Specifically, I am thankful to Dr. Holmes for his guidance in helping me to gain theoretical, methodological, and critical thinking skills, as well for his support to be brave throughout my research discovery. I also convey my appreciation to Professor Chartrand in helping me to advance my knowledge in Indigenous health and community health development. His gentle wisdom has been invaluable in helping me to realize my own path.

My gratitude extends to Drs. Stuart Murray and Amélie Perron for their critical theoretical contributions, and encouragement to discover my unique writing style. I also value the funding support for my Doctoral Fellowship from the Canadian Institutes of Health Research's (CIHR) Population Health Intervention Research Network (PHIRNET), and the Community Information and Epidemiological Technology with community support from the Aboriginal Nurses Association of Canada (ANAC). Additionally, I would like thank to Dr. Yvonne Boyer for her guidance on Aboriginal health and legal issues. In memoriam, I honour Dr. Dawn Smith for her gifts to community-based research through population health and public health nursing.

Happily, I thank my melody of friends, mentors, and students for their support and inspiration, as well as the communities that have embraced me along the way.

Specially, I would like to thank my sister, Aliyah Rahaman, and her family for supporting and celebrating with me every milestone achieved. Lastly, I express my appreciation to my brother, Dr. Omar Rahaman, and his family; and my amazing parents, Dr. Sheriff and Mariam Rahaman, for their encouragement to believe in my dreams and to follow those dreams fully.

To my family for all their love and support.

Introduction

Culturally responsive and holistic health care delivery and health promotion are prerequisites to improved health for Aboriginal peoples. This requires (...) an openness and respect for traditional medicine and traditional practices such as sweat lodges and healing circles (...)

- Kennedy, 1993¹

Culturally responsive health services delivery is an important part of nursing care to Aboriginal peoples. However, the scope of nursing care needs to be more inclusive of culturally responsive health care delivery and health promotion for Aboriginal peoples. Legally, the *Canadian Constitution* recognizes three groups of Aboriginal peoples including Indians (commonly referred to as First Nations), Métis and Inuit peoples (Government of Canada, 1982). These groups reflect:

Organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called 'racial' characteristics. (Royal Commission on Aboriginal peoples [RCAP], 1996a, p.xii)

Historically, Aboriginal peoples within rural, remote, and Northern Canadian communities have utilized nursing stations; for instance, for 'chest pains or colds' (as cited in RCAP, 1996a). However, the resources offered at the outpost nursing stations were not considered by Aboriginal peoples to be aligned with values of traditional medicine and were considered as foreign resources to Aboriginal peoples, as illustrated by the following memory:

¹ Original Source: Royal Commission of Aboriginal peoples , 1996a, Vol. III, p. 350.

I remember once sitting down with [a clan leader], and he was telling me that all the people were going down to the nursing station (...) But while they were walking down there, they were stepping over all the medicine from the land (...) When we go to the doctor and nurse, we give them our power to heal us when we should have the power within ourselves to heal us. (as cited in RCAP, 1996a, p. 349)

The system of utilizing health care programs and services delivered as part of European society often left Aboriginal communities feeling powerless due to the impact of colonization and its present day effect on the psyche of Aboriginal peoples. Today's generation of Aboriginal peoples within isolated Northern Canadian communities has grown up with colonization as part of their community landscape, in shaping how their communities function in terms of governance including health, economics, justice, and education. Through a critical theoretical lens framed by postcolonialism scholarship, research in nursing was conducted to better understand the impact of colonization's present day impact on health and how it may have contributed to the dominant discourse of health inequities and poverty often associated with being 'Aboriginal'. For instance, in a previous research study by Tang and Browne (2008), results showed that patients attending an emergency department were concerned with how they were perceived by health care professionals because of their appearance and how they might hold assumptions about them as 'Aboriginal' people.

Building on the growing body of postcolonial nursing scholarship, the research study presented within this dissertation expanded on the issues of racialization and culturalism from being the 'Other' within rural Canadian Aboriginal communities. The process of cultural awareness, including the gamut of cultural knowledge, cultural skill, cultural

encounters, and cultural desire, has its value in the delivery of health care services (Campinha-Bacote, 2002). However, advancing research through a postcolonial epistemic stance considers the socio-political and historical contexts that have shaped the current state of health care, in that:

Health care involving Aboriginal peoples in Canada continues to unfold against a backdrop of colonial relations that shape access to health care, health care experiences, and health outcomes. (Browne, 2005, p.63)

Situational, postcolonial scholarship can help provide researchers with critical analytical skills to go beyond racially-influenced assumptions that might influence poor health discourses within vulnerable populations. In particular, within this dissertation, postcolonial nursing research was used to explore the roles and challenges of nurses within rural Canadian Aboriginal communities as well as individual, organizational, and system level factors that support or impede nurses' work in meeting Aboriginal health needs. Nurses were challenged to frame the delivery of health services within rural Aboriginal communities going beyond provision to include services that are both culturally responsive and inclusive of health promotion. Consequently, the roles and responsibilities of nursing care for the health of Aboriginal peoples encourages nurses to be self-reflective in providing communities with respectful and dignified health services. Predominately, rural, remote, and Northern communities within Canadian provinces have a high percentage of First Nations people, as well as Métis populations; in this dissertation, these communities are referred to as isolated Aboriginal communities in Northern Canada.

Theorists including the work of: Frantz Fanon on colonization and being the racialized 'Other'; Julia Kristeva on semiotics and abjection; and, Michel Foucault on power/knowledge, governmentality, and bio-power were used in providing a theoretical framework to inform this qualitative study. Critical discourse analysis of twenty-five semi-structured interviews with nurses, physicians, and regional health care administrators was deployed in helping to gain a better understanding of the roles and challenges of nurses working within rural Northern and Aboriginal communities. Influenced by a postcolonial epistemology, the knowledge gained from this qualitative research study can help to better understand the roles and challenges of nurses working within isolated Northern communities, and with application help strengthen pathways for Aboriginal peoples' health.

As an overview, the first chapter describes the research problem where nurses' potential lack of knowledge about socio-political and historical contexts and their influence on health and health inequities can create a dominant discourse of subjugating practices that maintain the status quo of impoverished circumstances. Research objectives and the research questions, as well as the epistemic stance guiding the research study are also presented. Chapter two offers a literature review and discussion of current discourses about Aboriginal peoples' health within the body of pertinent literature. In addition, the theoretical framework is explained in chapter three, and chapter four presents methodological considerations. Research results are presented in chapter five, with a discussion in chapter six, followed by the conclusion.

1. Research Problem

Knowing is not enough; we must apply.

Willing is not enough; we must do.

-Johann von Goethe

1.1 Research Problem

The state of health affairs within Aboriginal populations is relatively poor and rapidly declining compared to the state of health within non-Aboriginal populations; for example, First Nations people and Inuit populations have higher rates of injury, suicide and many chronic and communicable diseases (Indian and Northern Affairs Canada [INAC], 2008). Aboriginal communities are struggling to obtain basic living conditions such as housing, adequate income, food supply, safe water and sanitation, and access to health care services (Canadian Population Health Initiative, 2004; Statistics Canada, 2008). These challenges to meet basic conditions for living contribute to nurses being overwhelmed, often resulting in poor job satisfaction and a high turnover rate of nurses within these communities (Stewart et al., 2005), thus affecting the delivery of essential health services to the communities in need and in right of dignified health services.

Regional health authorities and federal planners have a responsibility within the government's fiduciary obligation to Aboriginal peoples to provide health services that meet their health needs in a responsive and respectful way (Boyer, 2004). Nurses are an extension of the state health care system and they must provide responsive and relevant health services within isolated Canadian Aboriginal communities. However, there remains a lack of consensus about nurses' roles in these Northern health centres, where high

expectations, lack of a clear direction, and poor documentation burden staff, affecting the outcome effectiveness of care (Swider, 2002). Disaccord about nurses' roles thus adds to the uncertainty of their roles while working within rural Northern and Aboriginal communities.

1.1.1 Nursing Situations

Nurses are the largest group of health care providers within Canada, and are in a privileged position of working with populations to help advance health equity through advocacy and education. The scope of the nursing profession has a diverse range and its capacity can encompass health promotion, prevention of illness, and the care of ill, disabled and dying people in driving quality and equitable health care access throughout the life span (Canadian Nurses Association [CNA], 2003; International Council of Nurses, 2006). Despite nurses' responsibility to promote quality and equitable health access, health disparities and health inequities continue to exist.

Within rural Aboriginal communities, nurses are usually the sole practitioner providing health care services, and community engagement is difficult for nurses as they often feel like an 'outsider' of the community (Tarlier, Browne, & Johnson, 2007). The context of working and residing within isolated Aboriginal communities can be laden with hardships that make it difficult for nurses to practice (Vukic & Keddy, 2002). Specifically, the challenges of rural nursing include several factors, such as barriers to continuing education; experiences of overwork and burnout; lack of management support and appreciation; large scale of professional responsibility; inadequate schooling and employment for personal

family members; poor housing; and poor community amenities (MacMillan, MacMillan, Offord, & Dingle, 1996; Perisis, Brown, & Cass, 2008; Witham, 2000). Additionally, these challenges can also contribute to poor retention of nurses working within rural Aboriginal communities (Assembly of First Nations [AFN], 2005; MacMillan et al., 1996; Witham, 2000).

Under these demanding conditions, it can be difficult for nurses to fulfill their roles and responsibilities in providing equitable and effective health care for all, specifically, marginalized populations. Furthermore, it can be difficult for nurses to be effective within their roles without having an understanding of how health inequities within isolated Northern Canadian Aboriginal communities may be related to their various social and historical contexts.

Nurses who work within isolated Aboriginal communities are often recruited from outside the community and are generally unprepared for the 'culture shock' of working within a foreign community (Gregory, 1992). In these communities, nurses often feel like they are not part of the community, which may contribute to a high turnover of staff. A high turnover rate of nurses along with a shortage of nurses can negatively affect the delivery of consistent and effective health services within rural Northern communities (Lavoie, 2004). These problems are particularly acute at health centers within rural Aboriginal communities, resulting in poor level of quality or complete lack of essential health services (Perisis et al., 2008).

1.1.2 Environmental Site and Scan

Nurses within isolated Northern Canadian Aboriginal communities are facing many challenges in providing essential services to a population where health inequities have often contributed to a greater illness trajectory as compared to the general population (Perisis et al., 2008). For instance, over half of Aboriginal children live in poverty, over 60% of Aboriginal peoples do not complete high school, and 35% of Aboriginal families are headed by parents under 25 years of age (Statistics Canada, 2008). Not limited to these health inequities, Aboriginal peoples have less access to health services than non-Aboriginal persons due to geographic isolation and a lack of qualified health care providers to meet the health needs of the population; for example, 30% to 50% of Aboriginal communities are in remote regions that are usually accessible only by air (Postl, Irvine, McDonald, & Moffatt, 1994).

Rural residents rely on community health centers or nursing outpost stations to deliver essential services such as treatment and emergency services, as well as community health services including immunization, sexual wellness, dental health, diabetic education, and addiction counselling (MacMillan et al., 1996; Tookenay, 1996). Working in isolated conditions, nurses are exposed to socio-political and historical contexts that have influenced and continue to pose barriers to health care access. Nonetheless, the underlying causes of health disparities and health inequities must take priority in order to reduce the issues that often lead to major and avoidable ill health (Perisis et al., 2008).

In addition, these communities are at a further disadvantage due to the impact of colonization (Adelson, 2005). Literature on colonization is relevant in demonstrating the

continuing impact of colonization on First Nations persons (MacMillan et al., 1996). For example:

Aboriginal peoples' negative experiences with mainstream society relating to conscious or unconscious attitudes of health workers contribute to a reluctance [by 'Aboriginal' persons] to seek medical care until it is absolutely necessary. (Ellison-Loschman & Pearce, 2006, p. 614)

Furthermore, perceptions of Aboriginal peoples viewed as the racialized 'Other' can be considered barriers for Aboriginal peoples in accessing dignified and respectful health services.

Other barriers in delivering a high quality of health services can include the poor retention of nurses and lack of essential services within rural Aboriginal communities. For example, with a turnover rate as high as 40% within an 18 month period, it is difficult for rural community health centers to provide essential services that are not fragmented or declining in quality assurance (Minore, Boone, Katt, Kinch, & Birch, 2001). Challenges related to rural nursing vacancies and high turnover rates are primarily related to higher workloads, isolation, and rising costs (Witham, 2000). For example, the demands of rural and remote nursing may culturally challenge nurses partly due to barriers to continuing education, large-scale professional responsibility, and having minimal boundaries with community members seeking advice outside of the workplace or working hours (Perisis et al., 2008; Witham, 2000). Additionally, it is not uncommon for rural community health nurses to perform duties outside of their scope of practice, such as the prescribing, administering, or altering of medication, resulting in community health nurses wanting to leave their positions for less stressful positions (Witham, 2000).

Predominately, retention and recruitment strategies have focused on the medical profession within rural and remote communities; however, organizations also need to include retention and recruitment strategies towards nursing (Witham, 2000). Stakeholders responsible for providing health services within rural and remote First Nations communities are struggling to retain and recruit nurses within isolated areas. Difficulties in retention and recruitment are primarily due to the stress of working within isolated communities, such as “finding relief for time off or study, access to reasonable accommodation, inadequate salary, and gaining access to appropriate support, education, and training” (Witham, 2000, p. 19).

These stressors can contribute to the difficulty in retaining and recruiting rural nurses, often resulting in insufficient and fragmented health services delivery and can further contribute to the lack of hopeful discourse in addressing health inequities within these vulnerable communities. Spanning over the last two decades, research cited in this section demonstrates that isolated Aboriginal communities have experienced many years of health inequities. In chapter two, a thorough literature review will provide for a more in-depth view of the state of health affairs within isolated Northern Canadian Aboriginal communities, as well as nurses’ challenges in providing health services within these communities.

1.2 Research Objectives

Through a postcolonial epistemic stance, nurses' roles and challenges can be explored in relation to the socio-political and historical contexts that have contributed to health inequities, and can help address these within rural Aboriginal communities. The purpose of the study was to help better understand how nursing roles within an Aboriginal community have been shaped by socio-political and historical contexts. The findings of the study were used to understand the roles and challenges of nurses working within isolated Aboriginal communities, as well as to support renewed relations between nurses and clients in efforts to address health inequities in rural and remote Northern Canada.

1.3 Research Questions

1. What are the roles and challenges of nurses working within rural, remote, and Northern Canadian Aboriginal communities?
2. How can nurses help to improve the health of Aboriginal peoples within these vulnerable communities?
3. What are the individual, organizational, and system level factors that support or impede nurses' work in meeting the community health and cultural needs of Aboriginal peoples with respectful and dignified care?
4. What are the identified areas of knowledge gaps that can help nurses in strengthening pathways for Aboriginal peoples' health?

1.4 Epistemic Stance

Nursing care without nursing knowledge can have ethical and safety implications for the delivery of Northern health services to Aboriginal peoples. Within nursing as a practice, profession, and discipline, the development of nursing knowledge is vital to assess, implement, evaluate, and maintain services that are relevant and responsive to population health needs and outcomes. For the development of nursing knowledge, epistemology is considered. Epistemology is defined as the relationship between the person as a seeker of knowledge and the knowledge itself (Yorks & Sharoff, 2001). Knowing is an ontological, dynamic, changing process that is associated with how the self and world are perceived and understood (Chinn & Kramer, 1999). Nursing knowledge can be used to inform one's practice. The path to developing nursing knowledge depends on one's ontological and epistemological views of how nursing knowledge is developed. Knowledge development can be "accomplished through integrative strategies that preserve theoretical integrity and strengthen research approaches associated with various philosophical perspectives" (Weaver & Olson, 2006, p. 459). In its application, nursing knowledge can be flexible and adaptable to current contexts of reality and truths as reflected within practice.

Furthermore, nursing knowledge is described as a probable truth that is responsible, reliable, well-founded, and reasonable (Johnson, 1991); as a matter of context and perspective (Schultz & Meleis, 1988); and as being continually reconstructed rather than acting as a base (Payne, 2001). Knowledge development applied to nursing can be used to further transform nursing practice to be relevant and responsive to the community health needs of a population. For example, nursing is a transformative practice profession that can

help to address persistent health disparities within the complex context of health services delivery (Kirkham, Baumbusch, Schultz, & Anderson, 2007). Postcolonial scholarship offers researchers and theorists a critical lens to help explore health inequities related to its various socio-political and historical contexts.

In particular, the use of postcolonial nursing research can help contribute to a body of knowledge that is critically analytical of health inequities and social injustices (Racine, 2003). Furthermore, postcolonial scholarship positions nursing as a science and a practice within a framework to help address the impact of colonization on health and to create a new dialogue that shapes health experiences towards social justice and health equity (Anderson & McCann, 2002; Reimer-Kirkham & Anderson, 2002).

The relevance of critical theory to postcolonial nursing research involves nurses critically examining and becoming aware of the dominant discourses that influence how nursing knowledge is developed. For example, Holmes and Gastaldo (2002) suggest that nursing research is not neutral, apolitical, or ahistorical as nursing is governed by dominant discourses. Ekstrom and Sigurdsson (2002) view critical theory as a “valuable lens for viewing phenomena within socio-political context” (p.289). Guba and Lincoln (2005) argue that critical theories lean towards foundational perspectives with truth being situated in specific historical, economic, racial, and social infrastructures of oppression, injustice and marginalization.

A critical perspective can also frame nursing research that investigates the social phenomena from a position of within rather than from the outside. Mill, Allen, and Morrow (2001) claim that critical theory can help provide nursing research with a framework within

which to better understand the phenomenon of marginalization not from the outside (etic) but rather from a central position (emic). The emic stance allows for a stronger position in understanding social conditions, which helps inform practical interventions in nursing (Morrow, 1994). Nursing knowledge development informed by critical theory can also have practical and emancipatory functions at a broader level of nursing inquiry (Ray, 1992).

Critical theory can also initiate changes through “analysis and exposure of socio-cultural and political economical considerations of modern society that can restrict human activity” (Wells, 1995, p.46). Changes within nursing practice can help lay a “theoretical groundwork for more effective investigatory and practice action to ensure equitable access” (Stevens, 1992, p. 186). A fundamental focus of nursing knowledge within critical theory is action-oriented, to promote social change that accounts for the broader context of social injustices and health inequities. Within this dissertation, the theoretical underpinnings of postcolonial theory were used to better understand the impact of colonization and the neo-colonial present within the context in which health services is delivered within isolated Northern Canadian Aboriginal communities. Postcolonial scholarship in nursing is used to bring forward the issues of health inequities among Aboriginal peoples as related to colonization and racism within society, as well as nurses’ roles and responsibilities in resolving or contributing to health inequities related to the various socio-political and historical contexts in rural Northern and Aboriginal communities.

In chapter three, the theoretical framework is further discussed to explain how a postcolonial approach can help challenge the status quo based on norms of the racialized social system. Specifically, in moving forward, postcolonial research offers an analytical

framework to appreciate the historical basis of health inequities in including populations that have been excluded by being considered as the 'Other' based on 'racialized' differences (Anderson, Kirkham, Browne, & Lynam, 2007). Predominately, postcolonial research is used in understanding the impact of 'cultural production' that resulted from European colonization and imperialism (Ashcroft, Griffiths, & Tiffin, 2000). In this research study, these concepts are explored within postcolonial scholarship to help better understand the roles and challenges of nurses working within isolated Northern Canadian communities. Through critical research, the exploration of nurses' roles and challenges can help lead to a hopeful discourse in helping to address health inequities as related to the impact of colonialism on Aboriginal peoples' health.

2. Literature Review

Nothing ever becomes 'real' [un]till it is experienced.

- John Keats

Across the Canadian health care landscape, the experience of health distress is real for isolated Aboriginal communities in Northern Canada. In this chapter, the literature review presents the need to move beyond government public policies in addressing health inequities experienced by 'real' people within 'real' communities. Additionally, the literature review also includes frontline health dialogues on Aboriginal cultural competency, discourses about Aboriginal health and health inequities, primary health care, and more specifically, about work concerns related to rural Northern nursing practice.

2.1 Beyond Healthy Public Policies

In August of 2008, there was a press release by the Media Centre from the World Health Organization (WHO) claiming that *"social injustice is killing people on a grand scale"* [emphasis added] (Canadian Broadcasting Corporation, 2008).

In addition to this statement, the Director of WHO, Dr. Margaret Chan, offered in a press release:

Health inequality really is a matter of life and death (...) but health systems will not *naturally* gravitate towards equity. Unprecedented leadership is needed that compels all actors, including those beyond the health sector, to examine their impact on health. Primary health care which integrates health in all of government's policies is the best framework for doing so. (WHO, 2008b, para. 4)

At a global health level, social injustice is ‘real’ to the communities and populations that are facing health inequities, in part related to structural inequities. In 2008, WHO released a report by the Commission on Social Determinants of Health entitled *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Within this document, there were three recommendations that were offered in working towards closing the health inequity gaps through health policy. They were to:

(1) improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age; (2) tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life (globally, nationally, and locally); and (3) measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health. (WHO, 2008a, p.2)

These recommendations at a public policy level can act as guiding principles; however, the challenge is to implement these policies at a frontline level of care for the implementation and evaluation of population health outcomes. Similarly, the Canadian Public Health Association (CPHA) created a Frontline Health Program to help identify what public health agencies and other sectors are doing to address the social determinants of health and health equity in Canada, and how these experiences can be used to inform public policy and public health practices to achieve ‘health for all’ (CPHA, 2011).

Within isolated Northern Canadian communities, nurses are primarily the frontline care providers in delivering essential health services to Aboriginal peoples. Across Canada, these vulnerable communities are experiencing social injustices that are significant to the

population at large. The timely need for public policy development is emphasized by the gaps in service delivery within remote First Nations communities, such as: fragmentation of service, poor coordination of services between local health regions and federal governing bodies, and minimal involvement of community participants (Romanow, 2002).

2.1.1 Responses and Reactions

Although the development of public policy can be useful in helping to address health inequities faced by many communities, it will require considerable efforts beyond planning to address health inequities that are often rooted in social injustices. Additionally, it will also require the action of nurses at the frontline levels to provide relevant community health services. Aligning with the values of the WHO and the CPHA, nurses as frontline workers have a responsibility to help address health inequities and alleviate the suffering related to social injustices. The complexity in care is that it can be difficult for nurses to be effective without knowing the context of how these social health inequities were created. For example, nurses can be placed in vulnerable situations without knowing the socio-political and historical contexts of health care delivery within their working environment (Browne, 2005).

Specifically, it can be difficult for nurses to be responsive to the community's health needs, without the socio-political and historical knowledge of how these health inequities were created. In response, addressing health inequities at a community level will require nurses to be knowledgeable about the origins of health inequities before meaningful action can be implemented and evaluated.

In the aforementioned WHO document (2008a), as well as the Ottawa Charter for Health Promotion (1986), there was a move for public policy to be at the forefront of addressing health inequities from a national to a global level. In further review of these documents, issues of health inequities and social injustices were general to populations and not specifically mindful of how to address health inequities within Canadian Aboriginal communities. As such, Aboriginal organizations including those of First Nations representations, called upon national governmental actions to be more specific and purposeful to communities. For example, in 2003, the then-National Chief of Assembly First Nations, Grand Chief Matthew Coon Come, released a statement that spoke about the need for political action to address health inequities that moves beyond the known and the documented. As illustrated, the health inequities experienced by First Nations people were confirming:

The already well-known disparities in our health compared to non-Aboriginal Canadians. Most importantly, it highlights the health determinants that are directly related to our '*Third World*' health status; those socio-economic determinants include infrastructure, housing, employment, income, environment, and education. So far, this government is more preoccupied on spending millions of dollars to impose unwanted colonial legislation on First Nations rather than investing in measures that will improve our quality of life. (as cited in Adelson, 2005, S45)

The above excerpt from the former Chief of Assembly of First Nations illustrates the pressing demand for actions to be meaningful to First Nations communities in efforts to address health inequities and to help improve the quality of health services for First Nations persons. Poignantly, health inequities do not exist on paper, but rather are real for the

people enduring the hardships related to its various social determinants of health. Nurses, as frontline care providers, are in a position to help address health inequities within the communities by being involved in dialogue on building healthy communities for Aboriginal peoples. Preferably, these actions will (or would) originate at the community health level to help improve Aboriginal peoples' health, with public policy development to follow.

2.2 Frontline Health Dialogue

Frontline health is about the people, providers, and health services in rural, remote, and Northern Canadian Aboriginal settings. In these diverse communities, nursing roles are varied and unpredictable, making practice both challenging and rewarding (Priest, 2002). At the community level, frontline nurses are best situated to creatively respond to local health needs. Every day activities demand resilience, flexibility, and sensitivity. At the system level, these expanded roles and their toll on professional and personal life often go unnoticed. The Canadian Policy Research Networks (Hay, Varga-Toth, & Hines, 2006) in their report on frontline health articulate that support begins with recognition. Frontline barriers must be taken into account, such as issues with staffing, training and education, supportive networks, and funding.

One of the challenges is determining the true nature of rural nursing practice, as how to best educate and support nurses, given the panoply of experiences shaped by these diverse and unique communities, as well as the intricacies, assumptions, needs, and disparities of these marginalized populations. Hiring more staff, however, is simply not enough, as it fails to account for social, cultural, political, and economical factors.

Considerations to help address the issues that face frontline nurses and health care providers within their daily work place can also help alleviate pressure on the health system at a wider level of impact.

2.2.1 Critical Thoughts

Cultural competency can vary in its definitions in regards to the outcomes for clients and groups, the attitudes and behaviours of practitioners and organisations, or a combination of both. However, a common understanding emerges from the literature that cultural competence, attitudes, and skills are essential for its development of better health outcomes. For example, the purpose and outcomes of cultural competency development include:

The ability to maximize sensitivity and minimize insensitivity in the service of culturally diverse communities. This requires knowledge, values and skills but most of these are the basic knowledge and skills which underpin any competency training in numerous care professions. Their successful application in work with diverse people and communities will depend a great deal upon cultural awareness, attitudes and approach. The workers need not be as is often assumed highly knowledgeable about the cultures of the people they work with, but must approach culturally different people with openness and respect: a willingness to learn. (O' Hagan, 2001, p. 235)

From a health service delivery perspective, understanding the historical context of European contact, residential schools, and the multigenerational effect of residential schools can help health service providers to practice culturally competent care with Aboriginal clients. For example, the impact of residential schools has created

intergenerational trauma that can affect mental, physical, emotional, and spiritual well-being of individuals, families, and communities. Developing and utilizing cultural competency within practice, can help strengthen the quality and delivery of health care services, as well as the respectful treatment of Aboriginal clients and families. Cultural competency can be considered as a continuous process of learning and application rather than an outcome (Stanhope & Lancaster, 2011). Within the health care field, cultural competence can be defined as:

The capacity to provide effective health care taking into consideration people's cultural beliefs, behaviours and needs (....) Cultural competence is the synthesis of a lot of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding. Trans-cultural health is the study of cultural diversities and similarities in health and illness as well as their underpinning societal and organisational structures, in order to understand current health care practice and to contribute to its future development in a culturally responsive way.

(Papadopoulos, 2003, p. 5)

Developing cultural competency is an ongoing process that involves every aspect of client care. Two values that are useful in developing cultural competency can include: maintaining a broad, objective, and open attitude toward individuals and their culture; and avoiding generalizations based on one's own culture. Key aspects of cultural competency can comprise of cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interaction, and cultural skill. In contrast, barriers to developing cultural competency can include cultural blindness, culture shock, stereotyping, prejudice, and racism (Stanhope & Lancaster, 2011).

In application, increasing their cultural knowledge and skills about their clients' culture could help staff provide culturally competent care to Aboriginal clients and their families. The impact of culturally competent care could help Aboriginal clients feel that they are part of a health care system that values their culture, beliefs, and values. The removal of barriers of power and authority can help promote equality and work towards health equity and address health inequities. Health service providers also need a commitment from their organization in recognizing and respecting the cultural identity and diversity of Aboriginal peoples in order to provide respectful and dignified care, ultimately in working towards addressing health inequities for Aboriginal peoples within isolated Northern Canadian communities.

Culturally sensitive care can be closely tied to social, economic, and political processes, as well as power relations within Canadian society. Speaking to health care provision, cultural safety must be exercised, that is, the awareness and consideration of the impact of socio-historical and political structures on Aboriginal health and health care access, and how these have influenced clients, providers, health care practice, and the society at large (Browne & Varcoe, 2006). Unlike cultural competency, a means of providing culturally safe care, cultural safety is a process outcome, resulting from a paradigm shift in inherent power relations, wherein clients now perceive and determine the appropriateness and responsiveness of the health care encounter to their cultural needs (Smith et al., 2010).

Furthermore, cultural safety facilitates a critical understanding of the processes that influence health care relations, policies, and practices (Gerlach, 2012), wherein unconscious attitudes and assumptions of power that perpetuate inequities are exposed through self-

reflection. Because power now favours the individual, change and transformation must rather occur within health care providers, administrators, researchers, and policy makers. It requires an inward examination of how professionals are socialized into their profession, as well as their language, relationships, positioning, and the cultural nature of their practice (Browne & Varcoe, 2006). However, individual transformations are not enough to sustain culturally safe change; institutions too must be accountable as Aboriginal affairs have multi-jurisdictional implications (Waters, 2009). A critical discourse on culture and social justice is essential to challenge existing power structures, promote health equity, stimulate political action, and facilitate the inclusion, engagement and empowerment of Aboriginal peoples in health care decisions (Gerlach, 2012).

As First Nations communities embark on the road to self-governance, central to recovery are the concepts of self-awareness, choice, and empowerment (Green, 2010). Self-determination in health services delivery means the creation and say over culturally appropriate and responsive Aboriginal programs and services, respective to community needs, strengthening community health by reclaiming Indigenous knowledge, values, and traditions (Stout & Downey, 2006). This notion can carry over to self-determination as well as the transfer of responsibility and power over matters that can affect the health and lives of Aboriginal peoples.

In general, First Nations communities have greater control over local health services delivery, including health care costs, which have been met with hopefulness and resistance, given concerns over increasing demands on access, quality, and sustainability (Lavoie, Forget, & Browne, 2010). Even so, constitutional, financial, and legal constraints further

limit Aboriginal communities' power to define and decide what is best for them. Nonetheless, self-determination has empowered communities to regain some control over health, education, and socio-cultural initiatives, valuing their needs, wishes, identities, and rights (Waters, 2009).

2.2.2 Federal Stakeholders' Interest

Despite a mandate to promote and support the health of rural, remote, and Northern Canadian Aboriginal communities, numerous issues and challenges remain, particularly for communities at the margins of federal health discourses. Issues hardest to address in rural communities, as identified by the National Collaborating Centre for Environmental Health (van Balen & Moffatt, 2011), were an aging population, limited access to services, limited financial resources, and lack of affordable housing. Community-based services are dwindling, compounded by "an underdevelopment of health promotion programs, a lack of diagnostic services, poor access to emergency and acute care services and under-servicing of special-needs groups" (Ministerial Advisory Council on Rural Health, 2002, p. 2). In its recommendations, the Council called for inter-sectoral and cross-jurisdictional collaboration, as well as stakeholder involvement, in building healthy community capacity, infrastructure, community indicators, and rural and Aboriginal health curricula.

The Health Council of Canada (2013) in its progress report on *Health Care Renewal in Canada* highlighted issues of access, quality, and sustainability, specific to Aboriginal health. The Council commends collaborative initiatives among jurisdictions, health authorities, local health integration networks (LHIN), and Aboriginal organizations and communities in

working to improve health and health care access; for example, the tripartite or trilateral agreements between Aboriginal communities and the British Columbia, Ontario, and Saskatchewan governments, respectively, in the self-administration of Aboriginal health services delivery. Progress towards addressing health inequities, however, is uneven given the variability within and across Aboriginal communities. Limitations identified included a lack of measurable indicators, lack of multi-year funding agreements, as well as barriers in education, housing, and cultural competence.

Jurisdictional complexities in the provision of quality, safe health care further create gaps in services. Notably, *Jordan's Principle*, adopted in 2007, was the result of jurisdictional dispute over the funding of health services for a First Nations child with medically complex needs. This principle was named after a young boy, Jordan, who died while in the care of the government as there was jurisdictional debate as to who would fund health care services for him. The intent of the principle is to ensure that the point of first contact would be the primary funder for health care services (Federal-Provincial Exploratory Meeting, 2010). Provincial implementation of the child first principle has been lagging. However, as of 2011, only the Assembly of Manitoba Chiefs has endorsed an action plan to implement Jordan's Principle.

It remains unclear how many child first cases there is or has been; for instance, none according to federal officials, whereas thousands according to others (Federal-Provincial Exploratory Meeting, 2010). Equally ambiguous is the role of the local community in the care, coordination, and financial support of children with one or multiple disabilities as

there is no one to oversee its implementation, and costs such as recreation and housing remain unaddressed.

Like culture, Aboriginal health is influenced by socio-historical processes. As Aboriginal peoples engage in collective healing, gaps in culturally sensitive health care provision continue to persist. The current state of Aboriginal health and health services are issues of national importance, requiring continued action, inclusion, and respect for the human right to health and health care; and to secure a healthy future for generations to come.

2.3 Aboriginal Health

With the impact of colonization on a population, there is a wide range of impact on the health status and overall well-being of a population. It is well documented through literature that social and politico-economic marginalization plagued the physical, psychological, and spiritual well-being of Aboriginal peoples, further perpetuated by a long-standing history of oppression and discrimination, resulting in a state of dependency, substandard living, and Third World health status (Newbold, 1998; RCAP, 1996a). Given the effects of colonization and environmental displacement on individuals, families, and communities, great variability exists within and among the Aboriginal population, in terms of geographic location, language and traditions, health experiences and predispositions, and available resources (Richmond, 2007). However, an important consideration and clarification is that these cultural differences among Aboriginal peoples existed and were present before European contact. The multigenerational implications of these combined

effects further contribute to the health and socio-economic demise of future generations (Macaulay, 2009).

2.3.1 Canadian Demographics

In Canada, 1.1 million Aboriginal peoples comprise 3.8% of the Canadian population; 60% of which are First Nations people (Aboriginal Affairs and Northern Development Canada [AANDC], 2013; Statistic Canada, 2006). Of these, 48% live on reserves and 11% in rural settings (AANDC, 2013). There are approximately 615 First Nation communities, largely distributed throughout British Columbia and Ontario (Statistics Canada, 2006). Though a young population, the Aboriginal population is quickly growing at a rate six times that of the non-Aboriginal population (AANDC, 2013); attributable to high birth rates and increased self-reporting (Statistics Canada, 2006).

Yet, the persistent multigenerational impact of historical processes sustain current patterns of suffering (Richmond, 2007), perpetuating inequalities within these marginalized populations. For instance, life expectancy is below that of the national average: 68.9 versus 77, and 76.6 versus 82.1 for Aboriginal and non-Aboriginal men and women, respectively; as well, suicide rates are three times the Canadian rate (Health Canada, 2005). Negative health outcomes are also the result of behavioural risk factors. Aboriginal peoples are twice as likely to smoke, and more likely to be exposed to second-hand smoke in the home (Statistics Canada, 2013); and smoking rates are increasing (Tjepkema, 2002). Binge drinking and substance abuse are also a cause of concern (Newbold, 1998; Statistics Canada, 2013).

In 2000/2001, Lix, Bruce, Sarkar, and Young (2009) determined that Aboriginal peoples living in Northern settings were more likely to be obese and lack physical activity, compared to the southern population. In 2010, Aboriginal peoples living off reserve had higher rates of morbidity, chronicity, and mortality, regardless of smoking status, body mass index, contact with health services, or urban setting; however, some reduction were noted when factoring income and education (Garner, Carrière, and Sanmartin, 2010). Despite a long-standing history of adversity, the Aboriginal population remains resilient, finding strengths in renewed traditions amidst social and health inequities (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011).

2.3.2 State Health Affairs

The burden of illness borne by Aboriginal peoples is closely related to the political and economic systems that shape daily living and reinforce social disadvantage, in that the socioeconomically disadvantaged experience poorer health outcomes. Health equity, from an Aboriginal perspective, is defined as the equal distribution of health services to produce health outcomes equivalent to those of the general Canadian population, and must be equitable within and between Aboriginal peoples. For instance, the greater the burden of illness, the greater the healing response must be if the health and well-being of Aboriginal populations is to be as good as that of non-Aboriginal Canadians (RCAP, 1996). Social justice demands collective action to remedy health disparities and the unfair distribution of resources (WHO, 2008a). The time for political will, fairness, and change is now for health equity to move from universal goal to outcome.

Health Inequities

Integral to Aboriginal health is one's sense of balance, collectivity, and cultural identity. However, colonization and residential school systems through assimilation have fragmented Aboriginal families and communities, and have stripped them of their cultural ties to the land, the people, their heritage, and traditions. Health and well-being as a result have greatly suffered; for example, irrespective of geographical setting, Aboriginal peoples report poorer health outcomes and unmet health care needs, compared to the general population (Garner et al., 2010; Tjepkema, 2002).

Numerous studies have highlighted the need for further investigation into the upstream factors that sustain such disparities both directly and indirectly (Adelson, 2005; CNA, 2009; Garner et al., 2010; Newbold, 1998; Raphael, Curry-Stevens, & Bryant, 2008; Richmond, 2007; Richmond & Ross, 2009). For,

these health disparities are related to economic, political, and social disparities – not to any inherent Aboriginal trait – and because of the limited autonomy Aboriginal peoples have in determining and addressing their health needs. (Adelson, 2005, p. 46)

Though a federal responsibility, the state of health care delivery among the Aboriginal population remains below that of the Canadian population (Garner et al., 2010; Newbold, 1998). Issues with drug dependency rank among the highest health problems as identified in community surveys (Newbold, 1998). A greater likelihood of experiencing major depressive episodes was also identified (Tjepkema, 2002). From an injury standpoint, other concerns include the high prevalence of unintentional accidents, domestic violence, and

suicide (as cited in Richmond, 2007); for example, premature death among the Aboriginal population is 4.5 times that of Canadian society (Health Canada, 2005).

Given the intimate relationship between Aboriginal health and the environment, environmental dispossession from colonization has resulted in increased collective stress from a loss of control over life ways (Richmond & Ross, 2009). Similarly, the rapid post-colonial shift in traditional governance, economic means, and social and dietary practices further contribute to poorer health outcomes (Richmond, 2007; Tjepkema, 2002). Unfavourable health patterns have led to a two-fold incidence of cardiovascular disease, stroke, asthma, and diabetes (Garner et al., 2010; Health Canada, 2005; Lix et al., 2009; Statistics Canada, 2013). Aboriginal peoples are also more likely to suffer from co-morbidities than the non-Aboriginal population (Lix et al., 2009; Statistics Canada, 2013; Tjepkema, 2002), and suffer from activity-limiting conditions (Garner et al., 2010). Higher rates of infectious diseases and non-communicable diseases have also been documented (as cited in Richmond, 2007); for example, Aboriginal women are more likely to contract Chlamydia than their male counterparts are and are six times more likely than the Canadian population (Health Canada, 2005).

Social Determinants of Health

The abysmal state of health of Aboriginal peoples is multi-factorial and includes behavioural, socio-economic, post-colonial, institutional, and system-wide issues (Garner et al., 2010). Given the diversity and complexity among Aboriginal peoples and the variant health and historical contexts, a pan-Aboriginal approach is insufficient if relative health

equity is to be examined comprehensively (Adelson, 2005; Garner et al., 2010). In 1996, the Royal Commission on Aboriginal peoples stated in its final report that:

Aboriginal peoples in Canada endure ill health, insufficient and unsafe housing, polluted water supplies, inadequate education, poverty and family breakdown at levels usually associated with impoverished developing countries. (p. 1)

Nearly two decades later, the situation still persists. Low median incomes (\$22,000 versus \$33,000) and greater unemployment rates hinder socio-economic mobility, wherein the income of on reserve First Nations often falls below the poverty threshold at \$14,000 (Statistics Canada, 2006). Homes in Aboriginal communities are also in greater disrepair on reserves (45%) versus off reserves (17%), and compared to the non-Aboriginal population at 7 percent (Statistics Canada, 2006). Children are more likely to be raised in lone-parent households (Statistics Canada, 2006), where 41 percent of them live in poverty (as cited in Macaulay, 2009). Lower educational attainment is also common, where two thirds of Aboriginal adults do not have high school education (Statistics Canada, 2006).

To improve Aboriginal health, social, political, and economic factors must be improved. Within communities, Richmond (2007) demonstrated that both local context and broader societal processes interact to shape health-seeking behaviours in accessing care, including trust, group belonging, socio-economic dependency, poverty, and government paternalism. For example, Jacklin (2009) found that the healthiest, happiest, and wealthiest reserve on Manitoulin Island, Ontario was one that had remained relatively untouched by colonial influences, compared to other neighbouring villages. Attention must focus on health promotion via support for social justice, upstream activities focusing on large-scale

public health strategies, and cultural continuity, whilst diverging from the ‘colonial’ biomedical paradigm of disease (CNA, 2009).

If current health disparities are to be ameliorated, “greater individual or community control over resources and health management transfer policies may provide greater control over health and delivery of health care services in a more culturally appropriate manner” (Newbold, 1998, p. 72), a notion also voiced by proponents of cultural continuity (as cited in Macaulay, 2009). The issue extends beyond health care access; rather, it lies in delivering services that are socially and culturally relevant to local Aboriginal health needs. An integrated approach to improve social determinants of health requires action within and outside health care, and requires a paradigm shift from the individual’s responsibility to a societal issue, that is, the structural components that perpetuate the unequal power relations and health disparities of Aboriginal peoples (CNA, 2009).

2.4 Primary Health Care

2.4.1 Overview and Principles

With ‘health for all’ as its tenet, primary health care (PHC) as a philosophy and model for effective health care delivery fosters optimal health and wellness through the provision of health promotion and disease prevention, health protection, restoration and rehabilitation, and continuing care initiatives (CNA, 2013a), as well as “encourages the best use of all health providers to maximize the potential of all health resources” (Canadian Primary Health Care Research & Innovation Network [CPHCRIN], 2011, para. 2) within the community. Primary health care further recognizes the broad range of health determinants

that influence population health, such as social, economic, and environmental factors (CPHCRIN, 2011).

Derived from the Declaration of Alma-Ata, the CNA (2013b) outlines the following primary health care principles: 1) active participation of citizens, communities and populations, 2) public policy, 3) accessibility, 4) health promotion and chronic disease prevention and management, and 5) use of appropriate technology and innovation, that of knowledge, skills, and information. Nurses are in a unique position to facilitate health empowerment in individuals, families, and communities through health promotion strategies (CNA, 2013a), particularly in rural, remote, and Northern Canadian Aboriginal settings where they are often the main providers of health services (Bushy, 2002; National Collaborating Centre for Aboriginal Health [NCCAH], 2011; Tarlier, Johnson, & Whyte, 2003; Woods, 2013).

Access to health services is both a determinant of health and a principle under the Health Care Act (NCCAH, 2011). Ideally, equitable access is attained through fair and just distribution of health services and resources on a needs basis; however, significant disparities remain within rural, remote, and Northern Canadian Aboriginal populations (NCCAH, 2011). Contributing factors include socio-economic barriers, e.g. low income and educational attainment; environmental barriers, e.g. climate, locale, and transportation; cultural barriers, e.g. customs and linguistic background; and systemic barriers, e.g. appropriateness of services, scarcity of resources, provider shortages, and funding constraints (Ministry of Health and Long-Term Care [MOHLTC], 2008; NACCH, 2011). The Rural and Northern Health Care Panel, with a mandate to improve health care access and

achieve equitable health outcomes in rural, remote, and Northern Ontario, has developed a guiding framework for health care planning and delivery. The framework includes strategies and guidelines pertaining to governance and accountability, health human resources, and integration, particularly in the areas of public health and emergency services (MOHLTC, 2008).

Unequal access to health services in Aboriginal communities may further be explicated by the complexity of the health care system (NCCAH, 2011), where policies, legislation and funding, as well as the relationships between federal, provincial/territorial, regional, and Band authorities challenge and fragment the coordination of health services both on- and off-reserve (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011; NCCAH, 2011). The First Nations and Inuit Health Branch (FNIHB) provides primary care programs and services, including non-insured health benefits, to registered/status Indians living on reserves. Provincial/territorial governments, on the other hand, are responsible for physician and hospital care and see to the health of all other Canadians, including Métis, registered/status Indians living off reserves, and non-status Indians. The complex divide in health care systems can contribute to the challenges of providing health care services in meeting the diverse health needs and outcomes of Aboriginal peoples, and can account for some of the unequal access, coverage, distribution, and funding of health services within communities (Lavoie et al., 2011; NCCAH, 2011).

Partnership agreements between First Nations communities and the FNIHB are a promising means to optimize health outcomes. The 1979 Federal Indian Health Policy was a first step in recognizing that to improve the health status of Aboriginals, community

engagement in health program administration was required (Lavoie et al., 2011; Wigmore & Conn, 2003). A decade later, the Health Transfer Policy framework enabled for community control over the resources for community-based health programming (Lavoie et al., 2011; Wigmore & Conn, 2003), where three levels of community involvement were offered (Lavoie, Forget, Prakash, Dahl, Martens, & O'Neil, 2010), these being government-led, shared, or self-governed. The premise was that Aboriginal community members and health agencies are best situated in terms of knowing and managing *their* community's needs (Wigmore & Conn, 2003).

Currently, over 80% of Aboriginal communities eligible for transfer of control over community health services have done so (Lavoie et al., 2010b). As well, in their study on the impact of community control on health outcomes, Lavoie et al. (2010b) found a positive correlation between self-governance and health outcomes, with greater improvements noted the longer the autonomy over local resources. Similarly, a study on Manitoulin Island, Ontario saw improved community health by integrating existing self-governed health agencies into a regional health centre so as to "bridge community-identified gaps in services" (Maar, 2004, p. 56). Other documented benefits of community control over resources include: increased community satisfaction, empowerment, and accountability; greater awareness of health issues and community health needs; culturally sensitive health services; more employment opportunities for local paraprofessionals; and improved health outcomes (Lavoie et al., 2011; Wigmore & Conn, 2003).

2.4.2 Chronic Disease Management

Chronic diseases such as diabetes, cardiovascular disease, asthma and chronic obstruction pulmonary disease (COPD), arthritis, chronic kidney disease (CKD), HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), and mental illnesses which have long-term implications for individuals, families, communities, and the health care system. It's consequences have physical, psychological, and socio-economic impacts, and include disability, reduced quality of life, stress, loss of productivity, and premature loss of life (CNA, 2005). The WHO (2005) projects that from 2005-2015 two million deaths will occur in Canada as a result of chronic disease, which translates into a 15% increase in mortality. The reality remains that chronic disease continues to significantly and disproportionately afflict Aboriginal Canadians (NCCAH, 2010). Both an economically and socially marginalized population, multiple risk factors, such as behavioural, environmental and socio-political, underlie the occurrence and progression of chronic disease in Aboriginal peoples (CNA, 2005; NCCAH, 2010). The rapid transition in life ways from colonization has contributed to poorer health outcomes by influencing "the most proximal and modifiable risk factors for chronic disease: diet, physical activity and tobacco use" (NCCAH, 2010, p. 3).

The current biomedical illness model, with a focus on diagnosis and curative treatment, is insufficient in addressing, preventing, and managing chronic disease across the continuum of care (NCCAH, 2010; Registered Nurses' Association of Ontario [RNAO], 2009). Aboriginal peoples living with HIV/AIDS experience greater health disparities than other Canadians living with HIV/AIDS, and are more likely to receive a late diagnosis, late or inadequate treatment, and die from limited access to antiretroviral therapy (as cited in

Monette et al., 2011). In addition, the current system does not consider the emotional, intellectual, spiritual, and collective components of holistic health and well-being; rather, it focuses on the physiological aspects of disease (Harris et al., 2011; NCCAH, 2010).

Given the varied and fragmented state of health care delivery in rural, remote, and Northern Canadian Aboriginal settings, complicated by high staff turnover, limited access to physicians, and an acute care model, coordinating consistent and sustainable chronic disease management is proving arduous (Harris et al., 2011). One study on the clinical management of type II diabetes reported First Nations living in isolated communities had poorer glycemic control compared to urban dwellers with greater access to diabetes education (Harris et al., 2011); similar findings were also reported by Ashton and Duffie (2011) regarding the lack of screening practices for Chronic Kidney Disease (CKD) in underserved communities. Issues with access have also been documented in Alberta where Aboriginals living with asthma and COPD were more likely to visit emergency departments and less likely to see a specialist for their chronic respiratory disease (Sin, Wells, Svenson, & Man, 2002).

In Ontario, the Chronic Disease Prevention and Management Framework is making strides as a proactive, population-based approach at improving the health and quality of life of patients through collaborative initiatives, patient engagement, and evidence-based practice (MOHLTC, 2005). Within the primary health care system, nurses are well positioned as points of contact to best address health promotion and disease prevention, as well as foster trusting partnerships through ongoing supportive care (CNA, 2005). Within the Aboriginal population, nurses can “help bridge the gap in continuity of care” (RNAO, 2009,

p. 5) by listening to people's lived experiences, facilitating and advocating for community resources, and integrating holistic and culturally appropriate care into primary, secondary, and tertiary prevention (CNA, 2005).

Increasingly, preventative interventions are focusing on traditional knowledge, culture, and holistic approaches. For instance, traditional healing activities are proving effective to address the high rates of mental health problems within Aboriginal communities, and to help strengthen cultural identity, community solidarity, and political empowerment. As so, the focus is no longer on the troubled individual but "on the family and community as the primary locus of injury and the source of restoration and renewal" (Kirmayer, Simpson, & Cargo, 2003, p. 21). Increasing the cultural meaning and value of health care delivery will also help minimize impediments to access making care culturally responsive to the cultural needs of individuals and communities.

Also integral to health and quality of life is the capacity to choose, for "being able to live one's cultural values may be important in supporting healthy behaviours, as these traditional values serve as a basis for decision-making" (NCCAH, 2010, p. 6). The importance of choice was demonstrated in a report by the Central East Local Health Integration Networks (CELHIN, 2010) indicating knowledge, trust, and self-management as facilitators to behaviour modifications and treatment modality decisions in clients with CKD; further highlighting the strong correlation between empowerment, disease management, and health outcomes (MOHLTC, 2005).

Other holistic approaches have pertained to the provision of culturally safe and congruent programming, policy initiatives recognizing the benefits of traditional knowledge,

values, and activities in promoting Aboriginal health, and integrating health education within the community, including the home, police, schools, case workers, grocers, and community centres (NCCAH, 2010). Dismantling the long-standing factors and challenges that perpetuate chronic disease among First Nations will thus require the hybridisation of multiple models of care and health services, to include primary care, traditional healing, community health, as well as health promotion and disease prevention activities.

2.5 Northern Nursing Practice

Geographical, cultural, and socio-economical disparities, complexities, and constraints influence the vulnerable health and well-being of Northern populations. Care is structured within biomedical models, further controlling funding, programming, and governance. The present-day health disparities of socio-historical events that tax Aboriginal individuals, families, and communities may present challenges for nurses to navigate, as it has resulted in ill-burdened populations, disempowered and disengaged communities, and the inequitable access to and distribution of services, leaving nurses to care for a marginalized population. Even so, improvements in health services alone will not resolve the cycle of ill health; rather, political action on the socio-economic processes that perpetuate health disparities, such as poverty, poor housing, and unemployment, is needed in order to produce changes in practice, policy, and support to isolated Northern Canadian Aboriginal communities.

2.5.1 Racialization of Health Care System Delivery

With an emphasis on ‘multiple ways of knowing’ to inform nursing practice, nurses who work with Aboriginal populations must have knowledge into the historical and socio-political contexts, as well as the dominant discourses and attitudes, that currently affect individual and collective health (Foster, 2006; Smith et al., 2010). For the pervasive and oppressive impact of:

Policies of forced assimilation have had profound effects on Aboriginal peoples at every level of experience from individual identity and mental health, to the structure and integrity of families, communities, bands and nations. (Kirmayer et al., 2003, p. 18)

Despite this, many nurses are unaware of historical and long-standing struggles Aboriginal peoples face every day (Kirmayer et al., 2003). Further misunderstood is the divide in power relations that privilege and oppression create within the context, experience, and receipt of health care (Van Herk, Smith, & Andrew, 2011). A personal exploration of how these concepts impact professional practice is necessary in order to de-construct notions of ‘whiteness as normal’ and the marginalized ‘Other’ (Van Herk et al., 2011), and how they affect the manner in which care is provided.

Marginalized populations are those which live at the margins of dominant society, lacking inclusiveness, power, and importance (Jackman, Myrick, & Yonge, 2010), resulting in the loss of culture through separation, segregation, and assimilation (Bartlett, 2003). For Aboriginal peoples, the acculturation process led to oppressive colonial policies to ‘civilize’ the population. For instance, through the institutionalization of Aboriginal children in residential schools, the ‘sixties scoop’ of foster care, the exile of Aboriginal and non-

Aboriginal unions, the prohibited participation in cultural activities, as well as the governmental control over resources, land, and persons were forms of oppressive acts to try to 'civilize' Aboriginal peoples (Bartlett, 2003; Foster, 2006; Kirmayer et al., 2003). Nevertheless,

the genesis of pathology observed as disease and dis-ease within and between Aboriginal peoples clearly flows from 'stress phenomena' and related 'social and psychological pathology' that are the products of forced assimilation. (Bartlett, 2003, p. 165)

Such repercussions on health are intergenerational, and include psychological turmoil, psychosomatic symptoms, identity confusion, mental illness, insecure attachments, domestic violence, substance abuse, and suicide (Bartlett, 2003; Kirmayer et al., 2003; Tang & Browne, 2008).

Ideals of dominance, privilege, and power persist in current-day health care delivery. There is an accepted assumption by the urban majority that rural nursing care is less valuable and is inherently less powerful, both economically and politically, which in turn perpetuates marginal access to health services with visible health consequences (Jackman et al., 2010). Furthermore, best practices derived from mainstream society may not be culturally congruent or effective in meeting the unique needs of Aboriginal peoples living in remote settings as they fail to recognize their definition of health, local culture and traditional practices, as well as the socio-historical 'legacy' of colonization (Smith et al., 2010). Racialization in health care exists because of a taken-for-granted 'normalized' identity, which influences interpretations of health and behaviour; for instance, the

racialized construct of Aboriginals “possessing certain ‘cultural’ attributes that contribute to their ‘sickness’” (Tang & Browne, 2008, p. 115).

The assumption amongst health care professionals that ‘everyone is treated the same’ is also misconstrued as it does not account for the socio-economic inequalities, systemic constraints, and unconscious interpretations of marginalized groups (Tang & Browne, 2008). The hidden processes in which expectations, perceptions, and interactions with the ‘Other’ are constructed have been defined as ‘racial profiling’. Implications for practice culminate in preconceived notions, unsolicited labelling, unwarranted surveillance, and differential treatment, further explaining the reluctance of some in accessing care or ‘trusting’ the system (Tang & Browne, 2008). Nevertheless, *people* are not the same: they differ in cultural background, lived experiences, and historical legacies. Therefore, neutralizing interventions by ‘treating everyone the same’ undermines the existence of social inequities within society (Tang & Browne, 2008).

As knowledge is power, nurses must critically examine the relational power dynamics that influence current practice and social positioning, and how it may contribute to privilege and oppression (Van Herk et al., 2011) within clinical encounters:

In understanding our past relationships with Aboriginal peoples, nursing gains wisdom and insights which will illuminate the way of the future and prepare nurses to meet the health challenges that await in the next century and beyond. (Jackson et al., 1999, p. 102)

Such reflective practice must begin at the undergraduate level where students are socialized into their future roles as nursing professionals (Van Herk et al., 2011). An understanding of the socio-economic and historical structures that span across Aboriginal

populations is an important first step towards cultural safety (Smith et al., 2010). To achieve culturally relevant and responsive care, nurses must co-create health *with* Aboriginal individuals, families, and communities if ‘healing’ is to occur within the health care partnership.

2.5.2 Profiles in Practice

Nursing practice in rural, remote, Northern Canadian Aboriginal communities is diverse, and is shaped by the land and climate, isolation, community needs, available resources, degree of vulnerability, and nurses’ professional integrity. At its core is providing culturally responsive care, whilst fostering strengths and capacities among individuals, families, and communities. Rural nursing practice constitutes 18% of the Canadian nursing workforce (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). Rural nurses will become an aging population; for example, the average age of Aboriginal and non-Aboriginal nurses being 41.5 and 44.6, respectively (Stewart et al., 2006). Greater attrition rates amongst Aboriginal nurses in these communities are also present but remain unclear (ANAC, n.d.).

Nursing Roles

Nurses working in rural, remote, Northern Canadian Aboriginal settings are commonly referred to as nurse ‘generalists’ (Bushy, 2002; Leipert & Reutter, 1998; as cited in Tarlier et al., 2003), in that they provide intergenerational care to individuals and families for a variety of conditions, in a variety of contexts. As cited by the Canadian Association for Rural & Remote Nursing (CARRN, 2008), “nursing as it should be” (p.7). In such isolated settings, the

nature of nursing practice is complex and challenging, requiring nurses be competent and responsible in the management of acute and chronic health issues, often times functioning as multi-specialists (MacLeod, Browne, & Leipert, 1998; CARRN, 2008). To meet the challenges of day-to-day practice, rural nurses see their scope of practice expand in order to work within the primary health care context. For instance, everyday practice may require advanced knowledge and ability in, but not limited to, drug or volume replacement therapy, cardiac arrest, trauma, laboratory results interpretation, emergency deliveries, chest x-rays, and health teaching or counselling (Tarlier et al., 2003; Vukic & Keddy, 2002). Thus, the role of Canadian nurse practitioners today has evolved from outpost nursing pioneers (Tarlier & Browne, 2011), and given the paucity of rural physicians, nurse-managed care initiatives and nurse practitioners' regulation have helped fill this gap (MacLeod et al., 1998).

For newcomers, rural nursing presents a startling transition process, where flexibility is of necessity if one is to adapt to the social, structural, and cultural context of practice (Tarlier et al., 2003). For instance, limited resources make for increased autonomy, adaptability, creativity, and collaboration (CARRN, 2008; Leipert & Reutter, 1998; Tarlier et al., 2003; Vukic & Keddy, 2002). Technological savviness is also an asset given the increased provision of services and consultations via telehealth information systems (Bushy, 2002). Though sound primary care skills are integral for safe and effective care, particularly given the scarcity of physicians in rural and remote settings, these are not all inclusive. Roles must concurrently reflect community health, public health, and primary care needs in order for primary health care services to be deemed comprehensive (Tarlier et al., 2003), and to

address the social determinants that perpetuate health disparities within these communities (Tarlier & Browne, 2011).

Given the shift from a task-oriented to a community-centred approach to primary health care, nurses learn to build responsive relationships with the communities they serve, for mutual trust, respect, and active engagement have been attributed to positive treatment outcomes (Tarlier et al., 2003). Responsiveness to community strengths, priorities, and activities can also serve to minimize feelings of nurses as 'Other' (Vukic & Keddy, 2002). Given the limited resources, support from and collaboration with schools, police, employment and social services, and the Band office are also common (Leipert & Reutter, 1998). Consequently, the resulting formal and informal networks broaden nurses' access to valuable community information and resources, such as paraprofessionals, traditional healers, and Elders (Bushy, 2002). Nevertheless, rural nursing practice is multifaceted harnessing personal and professional characteristics of "resilience, resourcefulness, adaptability and creativity" (Bushy, 2002, p. 109).

Nursing Challenges

Providing complex, quality care within rural, remote and Northern Canadian Aboriginal settings is not without its challenges, and numerous concerns arise when socio-cultural, educational, and structural factors interplay, for the farther one is from key resources, the greater the hardships (Bushy, 2002). At its simplest, connections with the land and its people is what drives rural nursing practice. Difficulties arise however when personal and professional expectations are blurred "with little difference between work-home-

community” (Bushy, 2002, p. 107). However, this is a natural way of living and working for community health nurses accepting of Indigenous-based cultures.

Being the sole care provider at times, nurses have high public visibility, as well as formal and informal familiarity with residents, which can constrain such principles as anonymity, confidentiality, and integrity in and outside of practice (Bushy, 2002). Arguably, these are colonial values and would need to be negotiated differently in many Aboriginal contexts. For other nurses, the cultural shock experienced upon arrival, be it socially, environmentally, linguistically, or disparately induced, is enough to cause them to take refuge within the compounds of the nursing station. The resulting relational disengagement hinders both nursing practice and the community, however, as proactive responsive partnerships are neither sought nor fostered (Tarlier et al., 2007), which further perpetuates ‘Othering’ in that each party is an outsider to the other.

Nurses who work in indigenous communities are not necessarily oppressive. However, the environment in which they work is not conducive to problem-posing and a communion with the community, particularly if they are not from the indigenous community themselves. (Vukic & Keddy, 2002, p. 547)

There is an assumption that increasing the representation of Aboriginal nurses in the workforce can minimize ‘Othering’. However, the true solution lies within the confines of support, funding, policies, and legislation that mirror “broader social discourses about Aboriginal peoples” (Tarlier et al., 2007, p. 141).

Often, many non-Aboriginal nurses find themselves ill-prepared for the realities of nursing in remote First Nation communities, where social conditions and professional

expectations differ from any other practice setting, further compounded by complex health issues and social inequities (Tarlier et al., 2007). Though most nurses have experience in acute care, Tarlier et al. (2007) found that few had community health nursing experience. Health issues were more easily addressed at the individual level rather than at the community level or within a primary health care context, and such complacency “blinded nurses to the health disparities that were the real health challenges facing their patients” (p. 140). The challenges facing frontline nurses globally are also quite similar, particularly with respect to nursing education, retention, and recruitment (Bushy, 2002). Given the need for greater preparedness, little consensus exists on what comprises core rural nursing curricula (Bushy, 2002), with little focus on the socio-political context of nursing practice in rural, remote, Northern, and Aboriginal settings (Tarlier et al., 2007).

When considering recruitment and retention, rural ties often dictate those providers most likely to return, remain, and work in rural settings (Bushy, 2002). Often times, service may also be dependent on the fit between personal attributes, professional roles, and community needs and expectations. With First Nations’ movement towards self-health governance, greater community involvement in recruitment processes is thus expected and necessary to both facilitate professional relations and retention, and to counter high staff turnover. At the municipal level, northern allowances or other financial incentives aid with recruitment. Some academic institutions offer students rural placements (Bushy, 2002), whereas others facilitate entry into nursing programs for Aboriginal students (MacLeod et al., 1998). The Ministry of Health and Long-Term Care (2011) in Ontario also offers transfer tuition exemptions to students in return for rural service upon graduation.

At its core, if nursing education, practice, and health care delivery are to be improved, organisations and governments must consult with and involve frontline health professionals:

Buried in the discourse of nursing standards, quality of health care, health outcome, organizational requirements and the reality of work life issues, nurses are working in northern remote communities creating their reality of routine, order and relations with the community. (Vukic & Keddy, 2002, p. 543)

Day-to-day practice and resources is thus influenced by ethical, social, financial, and multilevel constraints (Bushy, 2002; Vukic & Keddy, 2002). The inclusion of Aboriginal stakeholders in health policy making is also “a necessary step in breaking the grip of a system that has never really been freed of its colonial roots” (Tarlier et al., 2007, p. 143). Fund reallocations, centralization of services, and cancelled programming have also furthered the gap in equitable access and outcomes for residents of rural Northern communities (MacLeod et al., 1998). Hence, public policy on health promotion and disease prevention must be at the forefront of the health care reform, including health planning, access, provision, and support.

The discussion of public policy needs to integrate the community’s health perspectives in an effort to create meaningful and culturally competent spaces for Aboriginal peoples. The following chapter brings forward a theoretical foundation influenced by the works of Fanon, Kristeva, and Foucault in illuminating how their theories can contribute to shifting the power dynamics from a colonial way to ‘new ways of being’ within a postcolonial era.

3. Theoretical Framework

Even if there is only one possible unified theory, it is just a set of rules and equations. What is it that breathes fire into the equations and makes a universe for them to describe?

– Stephen Hawking

Postcolonialism is the theory that was used to bring forward discourses about the current state of health care affairs within rural, remote, and Northern Canadian communities. As supported by the literature review, it is well documented that the state of health affairs among Aboriginal peoples is less optimal as compared to non-Aboriginal peoples across the Canadian landscape. For example, Aboriginal peoples regardless of where they live within Canada face unique health challenges including higher rates of diabetes, heart disease, tuberculosis (TB), HIV/AIDS, and many other diseases (Reading, 2009).

In 2009, Dr. Jeff Reading, the director of the Centre for Aboriginal Health Research at the University of Victoria produced a report entitled *The Crisis of Chronic Disease Among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*. This book draws attention to the acuity of chronic diseases among Aboriginal peoples, and the call for action for transformative changes, involving both Aboriginals and non-Aboriginals, for Aboriginal peoples to contribute to Canada's prosperity and development. Furthermore, the term 'rurality' including rural, remote, and regional areas, adds further challenges and vulnerability to Aboriginal peoples in terms of creating segregated and protected environments for non-Aboriginal communities from Aboriginal communities (Carter & Hollinsworth, 2009).

Through a postcolonial episteme, research is used to help address health inequities related to various socio-political and historical contexts within rural Canadian Aboriginal communities. One of the key distinctions of postcolonialism in being applied in the context of Aboriginal health is that research is used to 'speak of' the issues impacting the health of Aboriginal peoples, rather than 'speaking for them' (Greer & Patel, 2000). Moving towards addressing health inequities through a postcolonial perspective can help improve the health and well-being of Aboriginal peoples in Canada by contributing support, instead of imposing a constraining agenda.

The theoretical framework offered within this dissertation invites critical dialogue to go beyond the 'rationality' of why Aboriginal peoples are within their current state of health affairs. Rationality has often been used as a homogenizing force of modernity, which has produced the 'normalized' self-identifying Aboriginal subject (Tyler, 1993). Additionally, acts of 'hyper rationalization' and 'hyper differentiation' of the Aboriginal condition can further add to social tensions rooted in medical, administrative, and politico-legal instances of discursive fragmentation (Tyler, 1993). The intent of postcolonial scholarship is to move towards creating a forum where these issues can be brought forward to have practical applications in improving the quality of Aboriginal peoples' lives within real life events and situations. The theoretical framework of postcolonialism will be further described in relation to producing knowledge that challenges the status quo. Within the overall theory of postcolonialism, theoretical concepts including: colonialism and racial construction by Frantz Fanon; semiotics and abjection by Julia Kristeva; and, governmentality,

power/knowledge, and bio-power by Michael Foucault will be used to help work towards decolonizing practices by challenging the status quo.

3.1 Postcolonial Theory

3.1.1 Influencing the Nursing Profession

Over the past decade, nursing scholarship has seen a gradual shift in its focus on empirical science toward a more exploratory understanding through qualitative inquiry (Anderson, 2009). Changes within nursing inquiry are affecting the nursing profession due to a growing body of knowledge that challenges the status quo in efforts to promote social justice and health equity (Racine, 2003; Reimer-Kirkham & Anderson, 2010). In particular, postcolonial scholarship is gaining prominence in research as a means to critically examine the construction of knowledge shaped by cultural discourses within socio-political and historical contexts (Racine, 2009), and to transform nursing practice and policy (Anderson, 2009). Nursing researchers draw upon postcolonial theory as an analytical tool to illuminate how health care is, in part, socially constructed and to promote equitable access to health care (Anderson, 2000; Browne, 2007; Pauly, MacKinnon, & Varcoe, 2009; Racine, 2003).

Development of nursing knowledge from a postcolonial approach shifts research away from “ahistorical and depolarized models, and toward a more contextualized understanding” (Mohammed, 2006, p.107) of modern day issues. The philosophical underpinnings of postcolonialism draw upon multiple disciplines including philosophy, humanities, cultural studies, and literacy criticism, and will be used to discuss the legacy of the colonial past (Anderson & McCann, 2002). Aspects of present-day health care will be

explored from a postcolonial perspective to illustrate power dominance as seen within socially constructed concepts such as racialization, culturalism, and 'Othering' (Browne, Smye, & Varcoe, 2005). These concepts may present barriers where socially excluded groups such as 'Others' can be further marginalized within the health care system. Understanding health inequities based within social and historical contexts can help transform nursing practice to include all groups of society focusing on "sensitive issues related to race, gender, and class" (Racine, 2003, p. 91). A postcolonial perspective in nursing knowledge development goes beyond alleviating suffering associated with 'race-contextualized' thinking by working towards promoting equitable health care services.

3.1.2 Nursing Knowledge Development

Nursing knowledge developed through a postcolonial perspective can help contribute to a body of knowledge that is critically analytical of health inequities and social injustices in working towards change (Racine, 2003). In understanding how nursing knowledge is developed, it is important to examine definitions of nursing reflective of its practice. Nursing is viewed as an inherent human process of well-being, manifested by the complexity and integration of human systems (Reed, 1997).

Postcolonial scholarship positions nursing as a science and a practice within a framework to address the impact of colonization on health and to create a new dialogue that shapes health experiences towards social justice and health equity (Anderson & McCann, 2002; Reimer-Kirkham & Anderson, 2002). The path to developing nursing knowledge depends on one's ontological and epistemological views of how nursing

knowledge is developed. The interconnectedness between epistemology (an understanding the relationship between the researcher and being researched) and ontology (the nature of reality) within a particular paradigm will influence the way to see and understand the world through everyday experiences. In particular, the ontological and epistemological viewpoints help frame how nursing knowledge is developed and can be applied in supporting the social mandate to health in nursing. Postcolonial research situated within the paradigm of critical theory meets the ontological and epistemological imperatives in challenging standard practices toward creating new discourse and practices.

3.1.3 Paradigms

Nursing knowledge development is guided by theories in deciding the kind of knowledge that is needed in nursing practice (Chinn & Kramer, 1999). Nursing knowledge development through scientific research inquiry can be approached within a certain paradigm or 'world view'. Paradigms, as described by Weaver and Olson (2006), are "mechanisms to bridge a discipline's requirement for knowledge and its systems for producing that knowledge" (p.460). Kuhn (1970) describes paradigms as the model that scientists hold of a particular view of knowledge. Nursing researchers can utilize Kuhn's views of paradigms as a philosophical orientation in framing research inquiry, rather than as a basic truth (Thorne, Reimer-Kirkham, & Henderson, 1999). Development of nursing knowledge requires understanding who is the knowledge user and how that knowledge will be shaped. For example, nursing knowledge developed through a critical perspective accounts for the

social and historical contexts that has and continues to have an impact on health discourses (Anderson & McCann, 2002).

Sandelowski (2000) draws upon the scholarly works of Guba and Lincoln (1994), and Heron and Reason (1997), to describe that paradigms of inquiry are worldviews that indicate distinctive ontological, epistemological, methodological, and axiological positions. Paradigms are best understood as “viewing positions: ways, and places from which, to see” (Sandelowski, 2000, p.247). There are four paradigm divisions, namely, positivism, postpositivism, critical theory, and constructivism (Guba & Lincoln, 1994). A postcolonial framework is best situated within the paradigm of critical theory in understanding how to address societal issues related to social and historical contexts. With regard to the critical paradigm, postcolonial scholarship provides nursing research with “epistemological imperatives of giving voices to the subjugated knowledge [and] uncovering existing inequities and addressing social aspects of health and illness” (Reimer-Kirkham & Anderson, 2002, p. 1).

A literature review by Racine (2003) suggested that although postcolonial theory can be rooted in postmodernism to some level of analysis (Bhabha, 1994), critical theory grounds contemporary forms of oppression within social and historical moments to a broader extent than postmodernism. As such, critical theory is more analytical of history than postmodernism (Morley & Chen, 1997). Postcolonialism through critical theory counteracts the hegemonic effects of colonization as positioned within postmodernism (Bhabha, 1994). To further understand postcolonialism, critical theory is explored to gain an

understanding for its application to its various socio-political and historical constructs that shape dominant discourses.

Application

Postcolonial research offers an analytical framework to appreciate the historical basis of health inequities to include populations that have been excluded by being considered as 'Other' based on 'racialized' differences (Anderson et al., 2007). Postcolonial research predominately is used in understanding the impact of 'cultural production' that resulted from European colonization and imperialism (Ashcroft, Griffiths, & Tiffin, 2000). Racine (2003) provides a review of postcolonial research by drawing upon the literature of leading postcolonial scholars, including Said (2000), Quayson (2000), and Bhabha (1994). In *Orientalism*, Said (2000) described the political intellectualism of the British Empire over colonized subjects as a form of racism and imperialism in gaining social, economic, and political control. In *Postcolonialism: Theory, Practice, or Process?*, Quayson (2000) defines postcolonialism as a process of analysis that goes beyond the reference to another stage after colonialism as noted by the 'post', but it also denotes a continuing struggle against colonialism and its effects on the colonized.

In *The Location of Culture*, Bhabha (1994) argues that culture-based identities are associated with 'good' and 'bad' symbolism, and political discourses shape how relationships are developed in supporting cultures that are 'safe'. Bhabha (1994) examines the impact of colonization based in historical, political, economic, and cultural factors within the British Empire on the health of the people of the South through racism, sexism, and

classism. A critical examination of these concepts goes beyond the exploration of suffering to an analysis that explores the nature of oppression that is part of the everyday life experience (Anderson, 2004; Racine, 2003). For example, Racine (2003) claims that positioning cultural identity or race as an explanation for biomedical models implies that there are “unusual, intrinsic properties associated with being” (p.99) of a culturally perceived race in which these differences can be detrimental to a population. Nursing knowledge development influenced by a postcolonial theory can contribute to a body of knowledge that is critically analytical of health inequities and social injustices that reflect various social and historical moments. In working towards change, postcolonial researchers need to examine how practices are shaped by dominant discourses within health.

Although postcolonial scholarship is appreciated among critical theorists, it is not without its critics. Critiques of postcolonialism include that the process of researching a marginalized population can reinforce the experience of colonized knowledge by the dominant culture (Gregory, 2005). Researchers are thus cautioned about the colonizing potential of research itself (Browne et al., 2005; Smye, & Varcoe, 2005). Researchers within a postcolonial approach need to be aware of the potential implications of creating divisions between binary oppositions such as the colonized and the colonizer or the oppressed and the oppressor (Anderson, 2004). The caution lies in that the emphasis on the binary oppositions can reinforce the division between the dominant and submissive culture, and detract from its intended purpose to critically examine the relationship.

Criticism about postcolonialism can be met by understanding that postcolonial theory is intended to achieve respect for independence and diversity of a population.

A postcolonial perspective is relevant in helping health care professionals provide care and treatment to individuals, families and communities by exploring and understanding how “caring experiences are culturally, socially, and historically constructed in a gendered and racialized society” (Racine, 2003, p. 97). By being aware of the potential unintended and adverse consequences of postcolonialism research, such consequences may be overcome.

Postcolonial scholarship may be used within research and practice to address the impact of colonization on health care as it relates to cultural differences associated with racialization, culturalism, and ‘Othering’ (Browne et al., 2005). These concepts are explored in postcolonial nursing scholarship to help understand the roles and challenges of nurses in working towards equitable and dignified health care access and treatment for vulnerable populations.

Safeguarding Vulnerable Populations

In safeguarding communities and protecting Aboriginal peoples from vulnerability, there are several guiding documents that have been applied to research with Aboriginal communities and research involving Aboriginal peoples. These frameworks include the (1) Ownership, Control, Access, and Possession [OCAP] principles by the National Aboriginal Health Organization (NAHO, 2005); and (2) Chapter 9 of The Tri-Council Policy Statement [TCPS] entitled *Research Involving the First Nations, Inuit, and Métis People of Canada* (CIHR, 2007)². The underlying concept of safeguarding Aboriginal communities is to help protect

² *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* was first published in 1998. Amendments to TCPS were published in 2000, 2002, and 2005. The key principles of the TCPS, Chapter

the communities from research that may be misguided or harmful to communities (Castellano, 2004; NAHO, 2005). The shift in community-based research within Aboriginal communities stemmed from communities being tired of being “researched to death (...) maybe it is time we started researching [ourselves] back to life” (Castellano, 2004, p. 98). The intention of community-based research involving Aboriginal peoples is to help communities self-govern their own health affairs that are relevant to their own Indigenous worldview, culture, and practices. The context of the OCAP was created to help Aboriginal communities utilize knowledge gained from research for the benefits of the communities.

The timing of OCAP originated from the unity of academic scholars and researchers working together on research for the Royal Commission on Aboriginal peoples developed in the early 1990s (Castellano, 2004; NAHO, 2005). For further clarification, Indigenous scholars made a clear distinction between research and Aboriginal research, as follows:

Research means activity intended to investigate, document, bring to light, analyze, or interpret matters in any domain, to create knowledge for the benefit of society or of particular groups. *Aboriginal research* means research that touches the life and well-being of Aboriginal peoples. It may involve Aboriginal peoples and their communities directly. It may assemble data that describes or claims to describe Aboriginal peoples and their heritage. Or, it may affect the human and natural environment in which Aboriginal peoples live. (Castellano, 2004, p. 99)

The importance of OCAP and its application to research within Aboriginal communities was first used at a national level with the launch of the First Nations Regional Longitudinal

9, include: the respect for persons, concern for welfare, and justice. The application of these principles emphasizes the cornerstone of engagement in Aboriginal research (CIHR, 2007).

Health Survey also known as the Regional Health Survey (RHS) (First Nations Information Governance Centre, 2011). The significance of the RHS highlighted the importance of Aboriginal research being conducted in the community, respectful of the communities' values, as well as adding value to the community, rather than to the research community at large.

In addition to OCAP, the TCPS is also another guiding principle to “serve as a framework for the ethical conduct of research involving Aboriginal peoples” (CIHR, 2010). Both frameworks are applied so research conducted about or with Aboriginal peoples is used for the benefits of the community and not only for the profit or gains of researchers. In working towards goals of self-governance and self-determination, knowledge gained from this research study was applied to help strengthen the relationship between nurses and patients, as well as address health inequities through the delivery of relevant community health services.

Research does not have to be depleting or harmful to communities, rather it can help create a new pathway that invites healing from one's colonial past and its impact on present day social health issues for Aboriginal peoples. In gaining a better understanding of how postcolonialism scholarship can help in working towards a transformative change within health care systems, the theoretical concepts of racism and being the racialized 'Other' created within colonialism is discussed utilizing work borrowed from Frantz Fanon.

3.2 Frantz Fanon

3.2.1 Race Theory

In exploring the relationship of the colonizer and the colonized based on the concepts of racism, the two famous bodies of work of Fanon entitled *The Wretched of the Earth* (2004), and *Black Skins, White Masks* (2008), are well referenced by postcolonial scholars. Both texts by Fanon are based on his experience as an Antillean, but the experiences of colonial conditions can be applied to all relations of the colonized not just between black-white relations in general (Kane, 2007). In his book, *The Wretched of the Earth*, Fanon offers his theory of race and racism, where three elements are explored: “race as historically situated, race as culturally maintained, and racial constructions as embedded in human ontology” (Kane, 2007, p. 353). Elements that race is historically situated and culturally maintained will be further explored in understanding how racism was socially constructed through the development and maintenance of colonial relations and colonial practices based on race.

Colonial Relations and Colonial Practices

Relating to Fanon’s rejection of a “Negro essence” speaks to the concept that race is socially constructed as part of the biological determinism defined by the colonial master-slave relation (Kane, 2007). It is often within a colonized and colonizer relationship that there is a race that is marked superior to an inferior race. Race often denotes a class barrier, and the superior race often exists within a societal class that is preferred than the lower class. To exemplify this concept, Fanon explains:

Class and race gain meaning from one another: they are co-constituted as opposed to causally related (...) through

processes of differentiation that form specific kinds of spatial barriers between (poor) people of color and (rich) white people. (as cited in Kane, 2007, p. 355)

The association of the superior and the inferior has also been referred to by Honenberger (2007) as the colonial relation of the 'master' and the 'slave'. The relationship of the 'master-slave' is one of relationality between two consciousnesses. However as noted by Fanon, the 'master' does not have to be conscious of the slave (Fanon, 2008). In exemplifying his point, Fanon writes:

A member of the colonized people must be constantly aware of his position, his image: he is being threatened from all sides; impossible to forget for an instant the need to keep up one's defences. (as cited in de Beauvoir, 1992, p. 317)

The struggle to maintain the colonial relation often lies upon the responsibility of the colonizer. In application to colonial dialectic, the suffering of the colonized or the slave does not have much weight in social consciousnesses as a whole. For example, Fanon offers three possible scenarios for a former slave including the possibilities that "[he] has been set free; without a struggle, or into a racist social world" (as cited in Honenberger, 2007, p. 157). The experience of living in a racist social world is one suffered by the slave; whereas the experience for the colonized is to maintain his position of superiority, which can too be a struggle. However, the sympathy for the struggle of the colonizer often takes societal importance within the consciousness of the masses.

The division of the two consciousnesses is created and maintained by the meaning of what is given to one's race; hence creating interpretations of racism and defining the relations between the master and slave consciousness. For example, Fanon suggests that

the facts of race do not matter except in “the way in which race is understood” (as cited in Kane, 2007, p. 356). The essences of the master-slave relations that exist between the two consciousnesses can include:

(1) non-recognition, where each consciousness treats the other as a mere thing; (2) a fight to the death, where each consciousness recognizes the other as an absolute threat to its own autonomy; and (3) submission of one consciousness to the other, which leads to master-slave relations. The last stage includes that: (a) the appearance that the slave’s recognition of the master will secure the master’s certainty of his own autonomy, (b) the realization that such certainty cannot be gained from the slave’s recognition, and (c) the slave’s progressive realization of freedom both as an individual consciousness and in relation to the natural world. (Honenberger, 2007, p. 154)

As depicted by Fanon’s theory on race and racism, race is historically constructed and culturally maintained within the consciousness of both the master and the slave creating colonial practices inherent to colonially- and racially-based relations.

Race and Economics

Race plays an important role in creating colonial relations as well as colonial practices. Scholars drawing upon race as contributing sources to societal limitations and societal constraints understand that race can create objects through ‘archaeology of encounter’ (Harrison, 2002). In application to racism experienced by Aboriginal peoples, Harrison (2002) offers that colonial encounters based on race play a role in developing notions of social identity among antique collectors and Aboriginal peoples in the late nineteenth and early twentieth century. For example, within the collector items of Aboriginal peoples,

colonial images based on race were used to create a connection between practices of point manufacture and creating new hybrid, social identities (Harrison, 2002). Fanon's theory of race is best understood in that being a certain race or 'species' was given a meaning, in specific a 'hierarchical meaning' (Kane, 2007). Drawing upon Fanon's colonial notion that race is not reflective of biology, racism is thus historically situated, maintained, and created at different points in history.

Fanon claims that racism is not only linked to the meaning given to one's race within society, but also to the economic reality where one's race also holds meaning. For example, in *Black Skins, White Masks*, Fanon contends that culture plays a "role in maintaining and legitimizing the racialized economic hierarchy" (Kane, 2007, p. 356-357). Race is historically and culturally maintained through colonial relations and practices that have been based in economic realities. This concept was described by Fanon in the following:

The singularity of the colonial context lies in the fact that economic reality, inequality, and enormous disparities in lifestyles never manage to mask the human reality. Looking at the immediacies of the colonial context, it is clear that what divides the world is first and foremost what species, what race one belongs to. In the colonies the economic infrastructure is also a superstructure. (Fanon, 2004, p. 5)

The colonized relationship is based not just on race but also on economic history and status, which further embeds the relations of superiority-inferiority within society's consciousness.

The inferiority of the colonized is continually being culturally maintained and reinforced through economic realities. The impact of colonization on a population can lead to impoverishment that is often beyond economics, wherein the impact can be "transferred and internalized into the psyches and structures of society through the cultural component

of language” (Kane, 2007, p. 357). The inequalities of the colonized based on race and economics can lead to a ‘social suffering’ of a population where the pain and marginalization of a group continues to be maintained through colonial policies (Czyzewski, 2011).

In explanation, anthropologists including Arthur Kleiman, Veena Das, and Margaret Lock (1997), brought forward the concept of the ‘social suffering’ in their work entitled, *Social Suffering*. ‘Social suffering’ describes the consequence to groups of interactions influenced by political, economic, and institutional power, as well as what that impact may look like in terms of social problems to the people that have experienced those forms of power (Kleiman et al., 1997).

With applications to Indigenous populations, colonial practices can include colonial policies on Indigenous people including “genocide, which anchors colonialism”(Smith, 2010, para. 2). Fanon argues that colonial practices rooted in racial economical hierarchies were set in the time of colonization and continue to exist in the formulation of power over the colonized. The concept of social suffering can be interrelated to the existence that the colonized is constantly demeaned in society, whether it be in relation to one’s race or by economic influence. For example:

The colonized’s sector is a famished sector, hungry for bread, meat, shoes, coal, and light. The colonized’s sector is a sector that crouches and cowers, a sector on its knees, a sector that is prostrate. It is a sector of niggers, a sector of towelheads. The gaze that the colonized subjects cast at the colonist’s sector is a look of lust, a look of envy. Dreams of possession. (Fanon, 2004, p. 5)

Fanon suggests that the social suffering experienced by the colonized is created in the existence that the colonized wants what the colonizer has. However, when social suffering reaches a level of psyche that has been so embedded over time and in discursive practices, it can be difficult or almost impossible for that group to realize that there can be another type of existence except for the one realized. For the mystical past does not become mystical anymore, but realized and normalized.

Fanon further adds that the social suffering embedded in the psyche of the colonized speaks to the idea that there is “no memory of struggle in the former slave’s consciousness [and hence] the slave *himself* cannot be certain of his own value” (as cited in Honenberger, 2007, p. 158). In this sense, the slave or the colonized is trapped within his own consciousness, and his self-awareness is formed by the external conditions created within the systems of power. In application to Aboriginal peoples, Tyler (1993) suggests that ‘welfare colonialism’ exemplifies the formation and institutionalization of these conditions among Aboriginal peoples. For instance, the Aboriginal identity is grounded in fragmentation and it can be difficult for the Indigenous person to de-fragment their socially-constructed identity, especially when one’s self-worth is related to the values of work and land (Greer & Patel, 2000). To this construct, the social identity of the Aboriginal person has been historically and culturally maintained not only through race, but also through economics as part of the colonial legacy and current day impacts on the Aboriginal person.

The relevance of a colonial history lies in understanding what are the contemporary issues facing a colonized population, and how can community-based solutions help to address some of these present day issues with meaningful health care services. An

assessment of community affairs can help create change, not to correct the past, but rather work towards changes that need to be made in moving forward from a historical colonial past. Nurses can assist work toward social change by working with the community to build community health capacity and strengthen their relationships within the community and its various subpopulations including youth, women, adults, and elders.

3.2.2 Racial Construction

The 'Other'

Fanon's racial theory maintains that divisions based on race are constructed ontologically (Fanon, 2008), where the concept of 'Other' is used to signify racial differences, clearly distinguishing the power relationship between the one and the other based on the former group not wanting to be the 'Other'. Within the human psyche, the group not wanting to be the 'Other' group often has to work very diligently to maintain that relationship of clear distinction. This distinction is created and embedded in the human ontology. Fanon claims that the movement toward the white world creates the "effect of separating one from their former psychical space but also leads to psychic changes" (as cited in Kane, 2007, p. 357). This act of movement can often be harsh and radical in creating and maintaining those spaces, and is relational-based on not being the 'Other' and being the 'Other'.

The relationship of the colonized and the colonizer, the superior white and inferior black, and the master and slave speaks to the relationship that exists as the 'Other'. For example, Fanon offers that "not only must the black man be black; he must be black in relation to the white man" (Fanon, 2008, p. 90). The 'Other' takes on the sense of an

inferiority to the mainstream group, where 'alienation' becomes a part of the psyche of being the 'Other' (Kane, 2007). With the notion that racism is historically constructed and maintained in society by the 'historical-racial schema', this representation of being the lesser creates a narrative of superior-inferior relations based on race (Fanon, 2008). The concept of 'historical-racial schema' where the black body has an inferior status was described by Fanon in his book, *Black Skins, White Mask* (2008). In creating a historical-racial schema where race is not a biological trait, race can be considered as a 'historical accomplishment' based in history and cultural contexts (Kane, 2007). As so, the impact of the historical accomplishment can be maintained and ensured through economic dominance, where representations of that race become normalized over time.

Violence

Utilizing Fanon's definition that the 'Other' is the opposite of the 'white/rich/powerful world', but rather is characterized as the 'black/poor/alienated', creates what becomes known as 'compartmentalized' sectors, the results of colonization (Kane, 2007). Additionally, the impact of being compartmentalized creates fragmentation within society where the rights of the individual within the group may not exist, but instead are overshadowed by the rights of the group that the individual belongs to. As an example, Ivison (2003) offers the argument of how do one's cultural rights become distinguished from peoples' rights. In his article entitled, *The Logic of Aboriginal Rights*, Ivison (2003) questions if there are any Aboriginal rights, and if there are, then what kind of rights are they? The questions speak to whether Aboriginal peoples have individual rights as a person,

or whether they become a collective group where cultural rights may impinge upon a person's rights to be part of a people.

The struggle within the group of the 'Other' is often a struggle where the mainstream society is indifferent to the overall representation of that group. For example, Fanon argues that there is no conflict between the master and the slave (Honenberger, 2007). This lack of conflict or lack of awareness of the consciousness of the slave by the master can tempt notions of indifferences. The indifference of the 'Other' and the identity of the 'Other' can invite a context of violence where the 'Other' is attached to their identity based in the existence of being racialized. In this context, Fanon's concept of violence is contextualized as an impact of the colonialism process of colonizing the colonized. For example:

The colonial subject is a man penned in; apartheid is but one method of compartmentalizing the colonial world. The first thing the colonial subject learns is to remain in his place and not overstep its limits. (Fanon, 2004, p. 15)

In this sense, violence would be the impact of the colonized subject not expressing liberation or the true form of being without constraints or limitations as defined by the colonizer. The compartmentalization of being the 'Other' creates a tension in society where violence is part of the colonized subject's life. As illustrated:

Deep down the colonized subject knows no authority. He is *dominated* but not *domesticated*. He is made to feel inferior, but by no means convinced of his inferiority. He patiently waits for the colonist to let down his guard and then jumps on him. The muscles of the colonized are always tensed (...) The symbols of society such as the police force, bugle calls in the barracks, military parades, and the flag flying aloft, serve not

only as inhibitors but also stimulants. They do not signify: “Stay where you are.” But rather “Get ready to do the right thing”. (Fanon, 2004, p. 16)

The colonized are aware of the uneasiness of being who they are and live in constant tension within the society that has created and maintained their place based on the racialized ‘Othering’. Fanon’s concept of the ‘Other’ can extend into the process of ‘Othering’.

‘Othering’

The connection between the ‘Other’ and the ‘Othering’ is that racialization and culturalism are concepts that can describe the experience of being the ‘Other’ or the process of ‘Othering’ (Anderson et al., 2007; Johnson, Bottorff, & Browne, 2004). Canales (2000) explains ‘Othering’ is a process that is based on the relationship of the self versus the ‘Other’. The term ‘Othering’ can be used to describe the impact of colonization on marginalized populations thereby creating differences generally based on ‘race’ or ‘culture’ (Racine, 2009). The process of ‘Othering’ can create discourses of exclusion and marginalization that can have a further impact on vulnerable populations, contributing to experiences of exclusion from the mainstream society (Racine, 2009). For example, Racine (2003) interviewed Haitian caregivers within Canada who experienced discrimination by the mainstream society based on their skin color or political allegiances. Participants voiced being considered as ‘second order citizens’ within the dominant society based on inherent ‘relations of ruling’ (Racine, 2003), and felt they were socially excluded from mainstream society.

The barriers created within health care practices by viewing the excluded group as the 'Other' can further reinforce and reproduce positions of domination and subordination (Johnson et al., 2004). The experience of feeling like the 'Other' can contribute to feeling excluded by mainstream society in daily experiences. In application to the nursing care of vulnerable groups, Canales (2000) argues that nurses can include the 'Other' in care by developing a connection to the marginalized group. However, drawing upon Foucault's concept of technology of power (Holmes & Gastaldo, 2002), nurses need to be aware that the act of including the 'Other' can still be a form of power over a marginalized group. By recognizing this form of power, nurses can utilize reflexivity within their practice to purposively consider their goals in transforming their practice to meet the needs of the individual's right to health.

However, it is important for nurses to be able to recognize their reactions when working with marginalized populations. Concepts of abjection and challenging meaning through semiotics by Julia Kristeva can further help strengthen the need for a critical analysis of racism in society, specifically by critically analyzing nursing practice as a means of governing a marginalized population.

3.3 Julia Kristeva

3.3.1 Semiotics and Symbolic

The work of Julia Kristeva is well known for the interconnectedness between various concepts such as "oral and written literature, politics and national identity, sexuality, culture, and nature" (McAfee, 2004, p.1). Kristeva's main concepts within her body of

literature include: semiotics, psychoanalysis, and political theory (Kristeva, 1986). Kristeva is also known for her theory of language including the notions of *chora*, semiotics, and the symbolic, which can be useful in creating and clarifying the signifying process (McAfee, 2004). Kristeva's notion of *chora* stems from Plato's work, *Timeus*, where he explains how the universe was created. *Chora* refers to both "receptacle and nurse, that is the container and the producer, of what the universe is before and as anything exists" (McAfee, 2004, p. 19). The concept of *chora* is further explained as:

Once the subject has entered into the symbolic order, the *chora* will be more or less successfully repressed and can be perceived only as pulsional pressure or within symbolic language: as contradictions, meaninglessness, disruptions, silences, and absences. The *chora*, then is a rhythmic pulsion rather than a new language. (Kristeva, 1986, p. 13)

Kristeva utilizes the concept of *chora* to mean more than space but also as an "articulation, a rhythm, but one that precedes language" (McAfee, 2004, p. 18). The concept of language being more than just space has also been described as the "constitution of objects detached from its semiotic *chora*" (Kristeva, 1986, p. 13).

The importance of Kristeva's concept of *semiotic chora* adds value to language in identifying where the significance is placed on a subject or object. 'Significance' can be seen as a form of positioning, from which the different forms of modalities of signifying dispositions, practices and discourses become normalized within language (Kristeva, 1986). The symbolism used within language carries significance within its discourse, and challenging the meaning requires understanding the significance denoted within the symbolic meaning as it relates to its political discourse. The application of semiotics and

symbolism plays a role in understanding how practices maintain their positions of power within language. Challenging the position of power and the meaning reflected within its symbolism can thus introduce change within the system.

3.3.2 Abjection

Another key element stemming from Kristeva's work includes the concept of *abjection*. Abjection is described as the idea where "certain body orifices are perceived as dangerous, whereas others are thought of as neutral" (Holmes, Perron, & O'Byrne, 2006, p. 306). The concept of abjection can speak to the disgust that can play a part in the interaction between relationships, such as the relation between nurses and patients (Holmes et al., 2006). Specifically, the concept of abjection was useful in bringing forward how abjection plays a role in "understanding nurses' reactions of fear and repulsion when responding to particular patients or clinical situations" (Holmes et al., 2006, p. 306). The relationship between nurses and patients where nurses care for patients can be seen as one of 'power imbalance' (Henderson, 2003). This relationship is often situated with nurses' having more significance in the relationship:

Nurses believe they 'know best', and that patients lack medical knowledge; [further establishing] the perceived need for nurses to hold onto their power and maintain control. (Henderson, 2003, p. 501)

Abjection plays a role in society by illustrating how people and relationships came to be who and what they are, in that people or persons are "subject to all kinds of phenomena: their culture, history, context, relationships, and language" (McAfee, 2004, p. 2). Abjection

can be applied to relationships to gain a better understanding of how relationships came to be and how those relationships are defined by the meaning that they signify. For example, Holmes (2005) argues that nurses within forensic psychiatric institutions can act as agents of governmentality, and that “nurses and inmates are caught in a powerful web of power relations” (p. 12). This example demonstrates that nurses can be described as ‘objects of power’ (Holmes, 2005, p. 8), where through abjection, nurses utilize their self as ‘objects of power’ in maintaining distance from what they loathe. Abjection plays a significant role in understanding the power relationship between nurses and their clients, and, how that distance between the object and subject is sustainable within the nurse-client relationship. Within rural Northern and Aboriginal nursing practice, abjection may not play a major role in fearing the subject, but in not understanding the factors that have shaped the living context of the subject’s life.

Abjection within the nurse-client interaction speaks to the complexity of relations denoted by power over a subject. Abjection can play a role in understanding how nurses’ inspection of the Aboriginal person can impact the delivery and treatment of health services as the social identity of Aboriginality has become a symbolism of fear for the nurse within the nurse-client interaction. In this sense, the Aboriginal person is subjectified and the Aboriginal person’s sense of self is not separated from the value given to the subject. For example, Kristeva offers that the ‘self’ is a “master of her own being, subject to no one” (McAfee, 2004, p. 2). The significance of this statement denotes that the sense of self is often outside of the subject’s experience of the self, and the identity of the self is often “wrought in ways often unbeknownst to the subject” (McAfee, 2004, p. 2). For instance, the

Aboriginal person is often not aware of the social identity given to himself or herself as defined by society's fear of the Aboriginal person within the dominant power relationship, nor how this fear interplays in the delivery and treatment of health services. In particular, nurses' perception of working with 'Aboriginal' patients and their potential disgust for their patients' poor health status has exposed the need for health discourses to be brought forward in a societal context.

Kristeva (1982) claims that it is "not lack of cleanliness or health that causes abjection, but what disturbs identity, system, [and] order" (p. 4). Additionally, Kristeva (1982) adds that "the object has only one quality of the object- that of being opposed to I" (p. 1). In relation to the state of health affairs, abjection plays a role in denoting that Aboriginal peoples are subjectified within a system of order, and anything that challenges that system would deviate from the normalized. For example, historically, Aboriginal peoples were in control of their selves through self-governance, but due to the colonial process, the sense of the Aboriginal social identity was subjectified and the Aboriginal person was no longer in control of his or her own self. The following demonstrates the presence of the 'subjectified self' as part of the Aboriginal social identity within the dominant power relationship.

The Subjectified Self

As stated in the Royal Commission on Aboriginal Peoples' report (RCAP; 1996a), Aboriginal peoples "enjoyed good health at the first time of contact with the Europeans" (p. 111). There is evidence to suggest that Aboriginal peoples were a healthy population prior to the

impact of colonization by the European settlers, which resulted in the introduction of disease, the plague, mental disorders and other serious conditions (RCAP, 1996a). Further evidence as provided in the RCAP (1996a) by some Aboriginal historians relating to the impact of colonization on the determinants of health for Aboriginal peoples is supported by the following example:

Aboriginal peoples were not subject to disease, and knew nothing of fevers (...) They were not subject to gout, gravel, fevers, or rheumatism. The general remedy was to make themselves sweat, which they did every month and even oftener. (Cornelius, 1976)

This quote is not to suggest that Aboriginal health did not have exposure to a range of illnesses and diseases. However, the above quote speaks more to the notion of self-governance and control over managing diseases that would have otherwise been foreign to them as a population. The impact of colonization as situated within social and historical contexts still has a present day impact on Aboriginal peoples within aspects of their daily life including housing, health, education, and security (Smylie & Adomako, 2009). As so, poor health status does not independently rest on the failure of the health care system (Lemchuk-Favel & Jock, 2004), rather it is rooted within social and health conditions that have impacted and continue to shape health discourses for Aboriginal peoples.

Health care professionals including nurses that are recruited in rural Northern and Aboriginal communities are often unaware of the social and historical conditions that have influenced the poor health outcomes of the population (Browne, 2005). Lack of awareness of the social and historical contexts of health inequities can make it difficult for these nurses

to provide services that are reflective and responsive to the community's health and cultural needs.

Kristeva's concepts of semiotic *chora* analysis, symbolic, and abjection can be applied within nurse-client interactions to gain a better understanding of the motivation of nurses' interactions within their nursing practice of the marginalized person. A postcolonial approach can help nurses be aware of their own positions of power, and how their positions may affect the care they provide to the less privileged in society. Foremost, nurses need to be aware of their positions of power, before they can be responsible for their actions.

3.4 Michel Foucault

The work of Michel Foucault is well known for his notions of: power/knowledge; governmentality, and bio-power including anatomo-politics and bio-politics (Holmes & Gastaldo, 2002; Perron, Fluet, & Holmes, 2005). Foucault's work has been used in many disciplines to understand how professions, organizations, and institutions can control various forms of care as part of a governmentality over its subjects (Smart, 2002). Examples of institutions include:

The family, school, hospital, prison, commercial enterprise and so forth, the conduct of individuals and groups is directed, in short, it is subject to government. (Smart, 2002, p. xiv)

Critical analytical scholars often draw upon the work of Foucault to help make sense of complex issues within a contemporary context and to help with analyses of issues concerning "the body, identity and subjectivity, morality and ethics, and technologies of the government" (Smart, 2002, p. xii). Concepts borrowed from Foucault therefore help

understand how individuals and populations are controlled under the direction of governmentality.

The application of Foucault's ideas help provide a critical perspective in understanding how these concepts such as governmentality, power/knowledge, and bio-power may have shaped the roots of complex issues that are applicable to present day issues facing marginalized populations and vulnerable communities. Foucault's concepts can be applied within contemporary contexts to help provide tools in challenging the status quo, inclusive of health inequities and their various socio-political and historical contexts.

3.4.1 Challenging the Status Quo

Through a growing body of literature in postcolonialism, power relations within colonized ways of thinking are challenged to create new ways of seeing and understanding that may lead to change (Anderson et al., 2007; Reimer-Kirkham & Anderson, 2010). Postcolonial researchers can critically examine concepts of racialization, culturalism and 'Othering' as forms of oppression influencing discourse and practices (Browne et al., 2005). Drawing upon the work of Foucault (1980) in *Power/Knowledge*, these concepts can be explored in relationship to power dominance in projecting a certain truth based on 'racialized' differences (Anderson, 2004). Examples of nursing research which explore dominant discourses through a Foucauldian perspective include the works of: Anderson (2000, 2004); Anderson and McCann (2002); Browne et al. (2005); Holmes, Murray, Perron, and McCabe (2008); Holmes, Roy, and Perron (2008); and Racine (2003).

Within these research studies, postcolonial scholarship explores how colonizing practices may be exercised as a form of power. For example, Holmes et al. (2008) through postcolonial research critique how nursing best practice guidelines may act as colonizing practices through knowledge production. As depicted by Foucault, results of colonizing practices through knowledge production can delineate particular inclusions but also enforce boundaries of exclusion (Anderson, 2000; Anderson et al., 2007).

The concept of power dominance over subjects is used to illustrate the relationship of colonization in creating 'subjugated knowledge' for the gain of power structures (Anderson & McCann, 2002). Foucault's notion of power dominance within relationships provides postcolonial scholars a framework to account for the structural inequities that have been brought about by the histories of colonization (Anderson, 2004). For instance, truths that have been accepted can be critically analyzed through a postcolonial approach to uncover the structures behind the truths. Furthermore, critical examination of power dominance within relationships can impact the production of knowledge (van Dijk, 1992), resulting in the challenging of accepted standards and practices.

3.4.2 Power/ Knowledge

In an article by Banerjee & Tedmanson (2010), the authors wrote that management learning and public policy within Indigenous enterprise development in remote locations in Northern and Central Australia are based in a relation of political economy of 'whiteness'. The authors offer that policy development based in this relationship are "informed by discursive practices of whiteness and colonial-capitalist relations of power" (Banerjee & Tedmanson,

2010, p. 147). Foucault's concept of power/knowledge can be applied to the analysis of the power relation and control by government for its own use and strategic direction of Indigenous economic state of affairs. The ideas behind the concept of power/knowledge are further explored by Foucault's definition of power:

Power is relations; power is not a thing, it is a relationship between two individuals, a relationship which is such that one can direct the behaviour of another or determine the behaviour of another. Voluntarily determining it in terms of a number of objectives which are also one's own. (Burchell, 2007, p. 134-135)

In his writings, Foucault was inquisitive to how institutions were responsible for the care of individuals and populations through power relations (Ojakangas, 2005; Smart, 2002). For example, "power relations are embedded in social life, and as Foucault observes governmentality is an inescapable fact of social life" (Smart, 2002, p. xiv). The analysis of control over life lies in the operation of power influence over 'bodies' and that the government is interested in controlling the 'bodies' and the population. As cited in Perron et al. (2005), Foucault explains that "power aims to exploit bodies (actions and energy) in order to turn them into a useful and strategic workforce" (p. 537). Foucault also offers that there is a close connection between power and government:

When one sees what power is, it is the exercise of something that one could call *government* in a very wide sense of the term. One can govern a society, one can govern a group, a community, and family; one can govern a person. When I say "govern someone," it is simply in the sense that one can determine one's behaviour in terms of a strategy by resorting to a number of tactics (...) it is *governmentality* in the wide sense of the term, as the group of relations of power and

techniques which allow those relations of power to be exercised. (Burchell, 2007, p.135)

In this context, power and government are well interconnected in the working and controlling of the lives of individuals and populations. In marginalized populations, the connection between power and government over the lives of individuals for the use of the government is being examined through a critical social lens. For example, policies as extensions of governmentality emplaced upon Aboriginal culture and people can be 'disempowering and alienating' (Chew & Greer, 1997). The authors suggest that the need for accountability by the government is not enforced and is exerted as a power relation over Aboriginal peoples to maintain the current system.

Power exerted by government control as a technology can also be seen in the 'welfare colonialism' of Aboriginal peoples (Tyler, 1993). For example, the state of affairs of Aboriginal peoples has created a 'Fourth World' people where the identity of Aboriginal peoples has become normalized in the images maintained by the government (Tyler, 1993). This notion speaks to that of Aboriginal peoples not being able to maintain and control their own images or sense of self. Additionally, Roth, d'Haenens, and Le Brun (2011) offer the example that the integration of Aboriginal peoples as an ethnic minority and multiculturalism within Canadian broadcasting is a challenge to fair portrayal practices and employment opportunities as it exposes racial divisions and racial and cultural competency. This example highlights that the position of the marginalized self makes it difficult to achieve equal opportunity due to influences that are historically and culturally enforced within society.

Foucault's notion of subjectivity can be applied in that governmentality is used to maintain and control the images of a population for its own use as a strategic direction (Smart, 2002). For example, Foucault's studies of "madness, illness, death, crime, sexuality, and subjectivity" (Smart, 2002, p. xiii) are being analyzed in terms of 'governmentality' as well as 'governmentality rationality' which speaks to "how people are governed in modern society" (p. xiii); that is the 'art of governing people'. The meaning can be applied as purposes of control over a population and tools for control that are maintained and reinforced in society to create that sense of the distorted self. In speaking to the opposite of governmentality, Foucault might offer enlightenment as "man's release from the self-incurred tutelage" (Burchell, 2007). As further described:

Tutelage is defined as man's inability to make use of his understanding without direction from another. Self-incurred is this tutelage when its cause lies not in lack of reason but in lack of resolution and courage to use it without direction from another. (p. 29)

The existence of power and governmentality in the lives of the marginalized self can create a system of difficulty for the self to be actualized, as there can be many levels of barriers both historically and culturally embedded in society's collective whole. As illustrated, conditions such as poverty and lack of educational opportunities as described within the condition of 'Fourth World peoples' by Tyler (1993) will most likely be continued within colonial-capitalist relations of power (Banerjee & Tedmanson, 2010).

3.4.3 Bio-power

Power over Life

Bio-power is a Foucauldian concept that is used to describe the “many indicators of the interconnectedness between individuals and the state (...) characterized by the interconnection of two axes: *anatomo-political* (discipline of the body) and *bio-political* (population management)” (Perron et al., 2005, p. 536). The relation between the power and the State can be conceptualized in terms of either the actions of individuals or institutional agents, or the effect of structures or systems (Smart, 2002). Through the relation of power and the State, bio-power can be seen as a form of power to influence life control over the body and the population (Ojakangas, 2005; Perron et al., 2005), with the intended direction outside of the self. Additionally, bio-power is a model of power where the “care of ‘all living’ is the foundation of bio-power” (Ojakangas, 2005, p. 6). According to Foucault, bio-power can be defined as:

An essentially modern form of power and its purpose is to exert a positive influence on life, to optimise and multiply life, by subjecting it to precise controls and comprehensive regulations. (as cited in Ojakangas, 2005, p. 6)

Borrowing from Foucault’s notion of bio-power, the focus of bio-power over individuals and the population is not deduction, but rather production (Foucault, 1990) where the power within bio-power lies within the control and value over life and the significance given to life.

The essence of bio-power is that value for life is given as decided for the individual and population; and that love (agape) and care (cura), “care for the individual” can be the hidden foundation of bio-politics (Ojakangas, 2005, p. 5). Anatomo-political and bio-politics

are forms of bio-power used to administer control and care over the individual and community. As further illustrated:

Bio-power or power over life is a subtle and diffuse form of power, and its purpose is to manage and administer individuals, and by extension, communities and populations. (Perron et al., 2005, p. 537)

From *Discipline and Punish* (Foucault, 1995), anatomo-politics speaks directly to producing technologies that serve to exert hold over other 'bodies', not only doing what one wishes, but operating as one wishes (Perron et al., 2005). Anatomo-politics suggests that the 'body' is objectified as a subject. For example, the relations of power and knowledge applied to objectification, subjectification, and human sciences positions man to the "emergence, development, and consolidation of new objectifying and subjectifying technologies of power" (Smart, 2002, p. 105).

Ruling 'Race' Relations

Bio-politics is the other dimension of bio-power focusing on the "management and regulation of populations and their common characteristics" (Perron et al., 2005, p. 541). This power over life (bio-power), targeting individuals and communities, is not concerned with 'death', but with the inclusion through 'exception' (Ojakangas, 2005). The concept of exception plays a role in describing a "situation where the state of exception has become a rule, the law that is in force without signifying includes life in itself only by banning it" (Ojakangas, 2005, p. 9). In this form, exception means that the individual or community is included only by exception without significance. In application to Aboriginal peoples, bio-

politics has been demonstrated through the concept of producing 'survivors of *survivors*'.

For example:

Survivors of residential schools where the bio-political production of intergenerational impacts on a population [can be] culpable for the production of survivors of *survivors*. (Czyzewski, 2011, p. 11)

This example speaks to the notion that the lives and value of life of marginalized individuals and communities are not condemned to death, but rather to a life where value is only included in the state of exception.

Utilizing Foucault's notion of bio-power based on racism, bio-power in general can further be explored through the concept that 'legitimate killing' is valid within a population that was anticipated not to survive conditions of survival (Ojakangas, 2005). As cited in Ojakangas (2005), Foucault claims in his lectures at the Collège de France (1975-1976) that:

The more inferior species die out, the more abnormal individuals are eliminated, the fewer degenerates there will be in the species as a whole, and the more I—as species rather than individual—can live, the stronger I will be, the more vigorous I will be. I will be able to proliferate. (as cited in Ojakangas, 2005, p. 21)

Within bio-power, racism creates a relation where the inferior is defined and segregated from the more superior as purposively designed. The authors, Carter and Hollinsworth (2009), offer that Aboriginal peoples living within remote and rural communities within Canada created a form of 'segregation and protectionism', further creating the sense that these communities are included within society by exception. Bio-power can be applied to the population of Aboriginal peoples living within isolating communities due to the power

assigned over their population. For example, bio-power is applicable within populations in that “beings are no longer distinguished by a qualitative essence but by a *quantifiable degree of power*” (Ojakangas, 2005, p. 12).

Racism embedded within society’s values and beliefs can be detrimental to the survivor of the survivors. However, as bio-power pertains to controlling power over life, death is not the intended goal for this population. Bio-power is concerned with the survival and the inclusion by exception, but not necessarily the value of the population to excel within society. This level of power relations creates an ‘archaeology’ where the order of relations are understood and practiced in “laws, regularities, and rules of systems of thought in the human sciences” (Smart, 2002, p. 32). In controlling the power over life as deemed fit within relations of order, bio-power focuses on caring for the life through institutions of power. Within these institutions and operations of institutions, Foucault suggests that ‘violence’ is not the hidden form of bio-power but rather ‘care’ is the foundations of bio-power (as cited in Ojakangas, 2005).

In this sense, racism may not necessarily be a form of violence, but rather a form of care and control over the intended population, in order to help maintain the ‘archaeology of encounter’. In continuing the theme of ‘archaeology of encounter’ and social identity (Harrison, 2002), racism needs to be alive and maintained within society to continue the order of normalcy. Racism can be seen as a tool to maintain bio-power, as well as normalcy and the status quo. Examples of bio-politics that can maintain this form of rules and regulation can be seen within different institutions and its various modes of care such as nursing care (Gastaldo & Holmes, 1999). In addition, Perron et al. (2005) offer that nursing

practice can be an instrument of bio-politics and primary nursing interventions as a tool enforcing power over a population:

During an intervention, nurses accumulate an abundance of information about the targeted population who receive care. Nurses convey information about behaviours that should be adopted to preserve health and they collect patients' secrets using surveys and evaluations or through various forms of counselling. The promotion of health is accomplished at many levels and through extensive awareness campaigns aimed at informing the population of the risks presented by their practices. (p. 542)

In this example, power is demonstrated through nursing practice to govern the population and control the presenting risks within that population. Moreover, with bio-politics, the 'population' is constituted bio-medically as a population, not as a people.

Formations of ruling and governance motivated by racialized differences can also be evident in forms of government policies influencing the care over populations (Bohaker & Iacovetta, 2009), such as governance over Aboriginal peoples. For example, the Canadian government, specifically the Indian Affairs Branch as part of the Department of Citizenship and Immigration, wanted to include Aboriginal peoples as immigrants in the postwar period between the 1940s to 1960s. The aim of the strategic direction was to create a 'one-size fits all category' of societal Canadian citizenship (Bohaker & Iacovetta, 2009). The deliberate construction of Aboriginal peoples as immigrants through policies and State affairs can create a sense of control over Aboriginal peoples through inclusion by exception.

The forced inclusion created maintains power relations over the individual and population where such power relations are responsible for their care with inclusion without

significance. This example demonstrates that racism is a form of bio-power in maintaining power over life through segregation and racialized divisions, but also an action where the power over life can be controlled based on racialized divisions. Utilizing Foucault's concept of bio-power including anatomo-politics and bio-politics, racism may not be a hidden form of violence, but can be applied as a form of care and control over the body and population. In particular, the violence can be represented in the care over the governed body and population, and in turn, the impact of racism can lend the population to not realize the full potential of the self.

3.5 Integration of Theoretical Perspectives

In situating the qualitative exploration of the roles and challenges of nurses working within rural Northern and Aboriginal communities, a postcolonial approach provides the tools to explore how racism plays a part in nursing practice in governing a marginalized population. The theories offered within this theoretical framework include the racial theory and the racialized 'Other' by Frantz Fanon; semiotics and abjection by Julia Kristeva; and governmentality, power/knowledge and bio-power by Michel Foucault. The key elements that integrated the various theories together is that due to historical and socio-political contexts, there is a power relation between the object and subject where the subject is controlled and cared for by governing forces. Within Fanon's work, it was noted that the subject was identified by a racialized constructed social identity created in a relationship based on the colonizer and colonized. Poignantly, the relationship subjugating the colonized

in the consciousness of the colonizer is a crucial element in situating the power between superior-inferior relations.

Through Kristeva's theory of language, meaning created and communicated within language is further solidified within society's values through the power relations of the 'subject' and the 'object'. The subjectified self is alienated and isolated within society without possibilities of change unless there is a call of action upon the objects of power. Adding on with Foucault's theories, postcolonial scholars can deconstruct how power is applied within institutions to control power over life of individuals and communities through care. Foucault's work is applied to social justice by critically analyzing how care is provided by exception without significance.

All of the various theorists including Fanon's, Kristeva's, and Foucault's work can be well interwoven within postcolonialism to address how power imbalances of Aboriginal peoples within society are an issue that needs to be addressed today with both significance and immediacy as being part of the human condition. The work of these theorists is credible in offering a theoretical framework for critical researchers and scholars in nursing to probe beyond the given meaning of the inferior, insignificant, and irrelevant. Critical research influenced by postcolonial theory can help analyze how relationships in society have been created and maintained by power relations that govern individuals and populations. As cited by Fanon (2008), "[it is] no longer a question of knowing the world, but of transforming the world" (p. 1). The theoretical framework offered within this dissertation helps strengthen the aim that postcolonial scholarship is intended to achieve inclusion and equity, not by exception, but with significant meaning to the communities.

4. Methodological Considerations

A picture is a fact.

– Wittgenstein

Context is an important part of perceiving a picture. A picture can provide an overall scheme of what is going on, reflective of its past influences, and influencing its present day reality. The complex reality of delivering health services within rural Northern and Aboriginal communities can be difficult due to many challenges, including nursing shortages, difficulty retaining and recruiting nurses, jurisdictional debates as to who is responsible for the delivery of health services, and the geographical vastness in delivery of services. Regional health authorities and federal planners have a responsibility to provide equitable health care services to patients and community members who are, in turn, trusting personnel to meet local community health needs. Nurses, often the sole health care professionals within rural Aboriginal communities, are asked to fulfill these needs and are thus in a unique position to address health inequities. Through a postcolonial epistemic stance, qualitative research can help to explore the roles and challenges of nurses working within rural Aboriginal communities in developing knowledge that delves into the relationship of health inequities related to the accepted norms of a racialized and power-based system.

Qualitative research is situated within a context, and its basis lies in the interpretive approach to social reality and the description of being situated within a particular context (Holloway & Wheeler, 2010). Qualitative research has an exploratory position that can bring forward contextual knowledge that will help to support and challenge nurses within

their practice to help meet the health and cultural needs of Aboriginal peoples within a responsive and relevant way. Within this chapter, the applicability of qualitative research was situated with the value of exploring the roles and challenges of nurses working within vulnerable communities.

Specifically, Critical Discourse Analysis (CDA) is described as a methodological tool in working towards social change of a contextualized practice for improving the delivery and quality of health services for Aboriginal peoples. First, the contextual background of the research settings are presented, along with the methods of data collection including interviews with nurses and key informants (physicians and regional health care administrators). Key elements of the data analysis are also presented. Lastly, considerations of ethical principles and rigour are offered, adding to the depth and analysis of this study to reflect validity, transparency, and sensitivity.

4.1 Qualitative Research

The approach of qualitative research is 'context-bound' within the natural setting (Holloway & Wheeler, 2010), and has often been described as research that uses a naturalistic method of inquiry to "deal with the issue of human complexity by exploring it directly" (Polit & Beck, 2008, p. 17). Qualitative research utilizes an "interpretive, naturalistic approach to its subject matter" (Jones, 1995, p. 2) and is helpful in understanding the experience within the natural environment. For example within a qualitative research study, the experiences of people are 'context-bound' and each study reflects the uniqueness of the relationships, history, and location of the participants within that particular context (Holloway & Wheeler,

2002). However, the data collected and analysed within qualitative research can utilize an inductive approach that moves from the specific to the generalized, as well as from data to theory or analytical description (Holloway & Wheeler, 2010). The research study offered within this dissertation is of an exploratory nature that investigated the roles and challenges of nurses working within rural Aboriginal communities through a postcolonial epistemic stance.

Exploratory research was used to help better understand the context of nurses working within rural Aboriginal communities, as well as explore what were the other factors such as socio-political and historical contexts that have shaped current discourse about nursing practices. The experiences of nurses working within rural Aboriginal communities were 'context-bound'. Furthermore, the experiences of nurses can be generalized through an inductive approach to help explore the potential causes of conflict or tension in working towards moving nursing practice forward with a transformative social and health agenda.

In nursing, qualitative research can be a suitable approach to explore real issues that may overlap with nurses' values, including commitment and patience, understanding and trust, and flexibility and openness (Holloway & Wheeler, 2002). Qualitative research has its roots in anthropology, philosophy, sociology, and human sciences (Brookes, 2007; Holloway & Wheeler, 2002). This collective background of qualitative research is useful in understanding that nursing has a value in capturing and communicating experiences in health and health care services research, and can be used to influence health policies at a local and national level (Brookes, 2007).

Qualitative research has a history of being utilized in health and health care services research (Mays & Pope, 1995) and is gaining momentum with an emphasis on understanding the phenomenon from the subject's or client's perspective. Additionally, qualitative research is useful in the exploration of change or conflict (Holloway & Wheeler, 2010) and can be useful in yielding "rich, in-depth information that has the potential to elucidate varied dimensions of a complicated phenomenon" (Polit & Beck, 2008, p. 17). For example, the delivery of health services within these vulnerable communities can be a complicated phenomenon for practicing nurses without understanding how colonization and its present day impact on health has contributed to health inequities and the current health status of a colonized population.

Qualitative research being contextually situated provides a strong vantage point for nurses to explore their roles and challenges in addressing health inequities related to socio-political and historical events. A methodological approach should be guided by the purpose of the study, and an interpretive descriptive approach can be useful in transforming nursing practice in gaining a better understanding of the phenomenon (Thorne, 2008; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Qualitative research through a postcolonial epistemic stance considers how health inequities have been shaped by socio-political and historical contexts, and how this new knowledge can help transform nursing practice in working towards challenging the status quo to promote social justice and health equity (Racine, 2003, Reimer-Kirkham & Anderson, 2010). For example, qualitative research is useful in transforming nursing practice by describing, exploring, and explaining the phenomenon (Ploeg, 1999). In addition, qualitative research has elements of sensitivity

within complex situations that can help develop knowledge to address ‘real problems’, such as understanding the roles and challenges of nursing in providing equitable and humane health services to Aboriginal peoples within rural, remote, and Northern Canadian communities.

4.2 Critical Discourse Analysis

Complex issues can be described as “real problems [that] are serious problems that threaten the lives or well-being of many” and require real solutions (van Dijk, 1993, p. 252). The complexity of addressing health inequities within rural Aboriginal communities has lent itself to being researched through Critical Discourse Analysis (CDA). CDA is a form of qualitative research that is an appropriate methodological tool in critically analyzing the power dynamics, such as racism, culturalism, and ‘Othering’ that have been created and sustained within dominant discourses to normalize practices and to maintain the status quo. Within the Canadian landscape, Aboriginal peoples experienced many hardships related to social, political, and economic conditions, all of which have contributed to poor social determinants of health and poor health status (RCAP, 1996a; Smylie & Adomako, 2009). For example, various scholars in Indigenous health offered that the fundamental underlying social determinant of health is the effect of colonization (Smylie & Adomako, 2009). In exploring the issues of racism as part of colonization on Aboriginal communities, the use of CDA as a methodology enriches the understanding of complex issues promoting social change and health equity (van Dijk, 1993).

4.2.1 Marginalized Populations

In delving into complex issues such as the impact of colonization on the health and health status of a marginalized population, CDA is a suitable method of research to address such an issue. CDA involves critical analysis of the phenomena that are often embedded in societal structures through power relationships (Crowe, 2005; van Dijk, 1993). By studying how discursive practices have been shaped by dominant discourses and how nurses' roles and actions can impact client care, CDA is both an efficient and effective tool to explore the roles and challenges of nurses working within rural Aboriginal communities. For example, research studies have explored the delivery and quality of health services within Aboriginal communities through a postcolonial lens, namely the study as presented by Tang and Browne (2008) which utilized an ethnographic methodology in the exploration of the racialization of Aboriginal peoples receiving nursing care in emergency departments. Similar to an ethnographic study utilizing a postcolonial epistemic stance in a qualitative research study, CDA can expand the critical lens to address socio-political and historically based issues such as racialization within the context of social relations and language.

Although postcolonialism has its criticism from Indigenous scholars, a postcolonial epistemic stance paired with a CDA methodology offers a critical lens that is imperative in providing tension in researching issues relating to racialized matters. Criticism of postcolonialism from Indigenous scholars offer that colonization during the time of impact of European cultivation was never stopped and its present day impact is ongoing (LaRocque, 2010). However, drawing upon a critical lens of revisiting colonization by Emma LaRocque (2010) in *When the Other is Me*, tension is needed to address socialized issues that were

created and remained since the days of European ‘settlers’ or ‘settlement’, for there “cannot be racial politics without some racism in politics” (p. 9). This concept relates to the notion that racism can be embedded within the relation between the ‘master’ and the ‘slave’, and the colonizer and the colonized. Similarly, the concept of colonialism can be described as a relationship between the colonizer and the colonized (Memmi, 1965), a relationship which is based in the power relations inherent to colonization between the colonizer and the colonized.

The study of postcolonialism required the examination of racism through a critical lens to help move beyond socialized issues of racism. More specifically, racism is not an issue specific to non-Aboriginal or Aboriginal peoples or the colonizer or the colonized, but one of a “sociological and ideological problem, not a problem that is unique to a specific race” (LaRocque, 2010, p.8). CDA offers a critical perspective that is imperative in studying socialized issues such as racism and in creating new discourse patterns in working towards health equity and social change for Aboriginal peoples.

4.2.2 Relationship-based: Social Practices and Language

CDA is a textually based analysis that focuses on the relationship between language and power (Fairclough, 2001). CDA also focuses on how lingual text properties are textually influenced by socio-political practices (van Dijk, 1993). CDA is contextually situated and accounts for how dominant discourses may influence the relationship between nurses and clients. For example, CDA situates texts in their “social, cultural, political, and historical context” (Cheek, 2004, p. 1145), and is useful to critically examine how language has been

shaped by socio-political practices. CDA is a fairly new methodology as compared to other methodologies within qualitative research. CDA was developed in England in the 1970s, and became a more developed methodology in the 1980s with contributions from linguistic scholars such as Norman Fairclough, Ruth Wodak, and Teun van Dijk (Smith, 2007). Within this research study, CDA as defined by Fairclough was used in understanding the relationship between language and its social context. Fairclough (2001) describes CDA as a method of research that identifies the specific social context of the language used within a text.

CDA can be used within all written texts as well as interviews and policy evaluations in examining the relationship between language and socio-political contexts within discourse and practices (Smith, 2007). The goal of CDA is to analyze how an individual experience is socially and historically constructed by language (Crowe, 2005), and calls upon a wider examination of attitudes and prejudices based within societal structures (van Dijk, 1993). CDA has been used in a broad range of critical social and health studies, and can be used as a research method that fits well within discourse and practices related to nursing (Smith, 2007).

Indeed, CDA is a methodological approach that is gaining recognition within qualitative research in nursing and social sciences as a means of working towards social change and health equity (Cheek, 2004). CDA is distinct from discourse analysis for its critical examination of the 'ideological underpinnings' of discourses that have become acceptable over time as a natural part of discourses (Teo, 2000). Fairclough offers that the ideologies and ideological practices may become "naturalized and [come] to be seen as

commonsensical and based in the nature of things or people, rather than in the interests of classes or other groups” (Fairclough, 1995, p.35). CDA is a method that allows researchers to question the status quo through critical analysis of discourses that have become ‘naturalized’ over time and accepted as being the normality (Crowe, 2005). Through the application of CDA from a postcolonial lens, naturalized practices are challenged to explore how practices that have been shaped by colonizing discourses can be reshaped through new knowledge. For example, CDA relies on critical inquiry to examine the relationship of ‘social and language’ in working towards social change (van Dijk, 1993)

4.2.3 Critical Goals

In use, CDA provides an environment to critically analyze the normality that has often been associated with standard practices. In application, CDA can be used to identify underlying issues, ultimately improve nursing practice to meet Aboriginal community health needs with respectful and dignified care. According to Fairclough (1995), the adoption of ‘critical goals’ is a fundamental basis in CDA in understanding how social practices are discursively shaped as well as understanding the discursive effect of these practices. This ‘critical goal’ in CDA distinguishes itself from basic communication in going beyond interpreting meaning from texts for the purpose of communicating particular phenomena of study. Fairclough (1995), relying on Foucault’s notion of power and knowledge, examines the power relations involved in discourses and practices. Foucault’s work, in the context of critical theory, has often been referred to as a ‘toolbox’ approach in exploring phenomena through contextual effects of power, knowledge and values (Manias & Street, 2000). This toolbox approach

offers a 'useful tension' to question the status quo by critically examining how discourses and practices are embedded within societal structures (Manias & Street, 2000).

CDA focuses on questioning the 'relationship' between "discourse, power, dominance and social inequality" (van Dijk, 1993, p. 249). Specifically, CDA studies phenomena that go beyond seeking mutual agreement to critically examining discourses, as well as understanding how language is shaped by socio-political practices. In application, CDA can help nurses be aware of the roles and challenges within their relationships with their patients and communities. For example, CDA is an effective research method to analyze how power dominance can construct subjects, in this case, patients for the purpose of governmental control. Relying on Foucault's terminology, it can be said that nursing care is a means of 'governmentality' (Coyte & Holmes, 2006; Holmes & Gastaldo, 2002), whereby nursing practice is a form of governmental control and exercise of power (Gastaldo & Holmes, 1999). Foucault's notion of 'governmentality' describes the "general mechanism of society's governance and does not refer specifically to the term of government as commonly used" (Holmes & Gastaldo, 2002, p. 559).

The analysis of discourse through a Foucauldian perspective offers that power is not a possession, but an exercise (Manias & Street, 2000). Power, as depicted by Foucault, is widely distributed throughout society and operates through many locations and relations (as cited in Payne & Nicholls, 2010; Perron et al., 2005). Nursing roles and the challenges of working within rural Northern Canadian Aboriginal communities can be explored to understand how social and historical contexts have shaped nursing care as part of governmental control over the Aboriginal population. In particular, CDA was used in

understanding how nurses were acting as agents of the state in efforts to maintain their power relation over Aboriginal peoples through their nursing practice within rural Aboriginal communities.

In providing a historical background, nursing care as part of the delivery of health services to Aboriginal peoples has and continues to be influenced by social and political contexts rooted in the seclusion of Aboriginal peoples from European settlers (RCAP, 1996a). Aboriginal peoples have been viewed as a population in need of containment on 'reserves', through the use of medical surveillance, in order to prevent risk to the mainstream society (O'Neil, Reading, & Leader, 1998). However, Aboriginal peoples had their own healers rooted within their cultural knowledge and practices. Yet, healers were not encouraged. Medical care including nursing care was sparsely supplied to Aboriginal peoples until the population posed a health risk to the mainstream population.

Nursing care was used as a form of action in preventing the mainstream society from harm and risk from the Aboriginal population. For example, public health services were first offered by the federal government to Aboriginal peoples to manage the spread of disease from contaminating the mainstream population (Lavoie, 2004). The first on-reserve nursing station was set up in Manitoba in 1930, and nursing care in rural and remote areas was used mostly to control contamination and harm-reduction to non-Aboriginal communities (Waldram, Herring, & Young, 1998). Nursing care was utilized as a form of action in the production and maintenance of patients under the government's control and is thus considered as a form of 'medical surveillance' (O'Neil et al., 1998).

Health economics refer to medical surveillance as a form of governmental control that continues to exist via inadequate funding structures and jurisdictional debates over who is responsible for providing care to Aboriginal peoples (Lavoie, 2004). Understanding how nursing roles and challenges have and continue to be influenced by dominant discourse can help nurses to be more reflective over their discursive practice. The above examples used demonstrated the use of governmentality and the role of imperial hygiene demonstrates that there is a socio-political and historical context to the delivery of health services within rural Aboriginal communities. Reflecting on their relationships with the government and their patients through language, nurses can use this awareness to shape their practice in meeting the health and cultural needs of Aboriginal peoples.

4.3 Research Settings and Recruitment

The presentation to recruit potential participants was given on several occasions to employees of the local health region to ensure that nurses and other health care professionals were aware of the study and had an opportunity to ask questions about participating in the study. Additionally, the Principal Investigator met with the nursing staff and managers of each department, introduced herself, and provided an overview of the research study. The purpose, methodology, and potential contributions were described to the participants. The purpose of the study was described as to explore how nursing roles might be shaped by social and historical contexts within rural Northern and Aboriginal communities.

In addition to the nursing shortage faced by rural communities, conducting research in Northern Saskatchewan created a privileged setting for studying issues that are relevant to nurses working within isolated Northern Canadian communities. Being true to a qualitative study, the research was conducted with participants within their natural setting. The following provides a contextual description of the research settings, both province wide and locally.

4.3.1 Contextual Description

Similar to the Canadian landscape of issues concerning the state of health care affairs for Aboriginal peoples, Saskatchewan is “influenced by culture, shifting demographics, geography, increasing population and the challenge of blending contemporary medicine with traditional healing” (Dagnone, 2009, p. 19). The research site, a Northern health region in Saskatchewan, included interviewing nurses working within acute care, community health nursing, emergency care, and public health nursing. Nurses working within this health region had an opportunity to work with the people of the community to provide meaningful care. This contextual background leads to a research environment about the delivery of health services best suited for a postcolonial perspective in understanding how to address health inequities in relation to various socio-political and historical contexts.

Recently, conditions of the health care system delivery in Saskatchewan received an unfavourable standing regarding equitable and fair health services in the *‘Patient First Review’*; within the report, the analysis offered that the health system struggled “to meet the demands and maintain basic safety and accessibility standards while often failing to

adopt practices that ensured high quality” (Dagnone, 2009, p.1). In summary, the State health care system received a failing report card. Several factors including escalating costs and a high senior population projected that the province would not be able to sustain its current health care system. For example, the budget had increased to \$4 billion dollars in 2008-2009, resulting in a 63% increase in budget from five years before (Saskatchewan Health, 2009). Despite escalating costs, the costs were “not associated to high quality of care or satisfaction with the delivery of health care services” (Dagnone, 2009, p. 3). Concern for an equitable and fair health care system, including “the development of a comprehensive plan for rural and remote service delivery” (p. 16) was a pressing issue to residents and industrial stakeholders.

The *‘Patient First Review’* also looked at challenges related to the delivery of health care services for Aboriginal peoples predominately within First Nations and Métis communities. Specifically, Aboriginal peoples in Saskatchewan including First Nations and Métis people spoke of hardships they endured as part of the standard of delivery and quality of health services that they experienced within their communities. For example, residents of remote First Nations communities were not able to access transportation for medical care because they could not afford the cost of multiple trips for prescribed treatment (Dagnone, 2009). In creating change, the *‘Patient First Review’* recommended that First Nations and Métis people need to be involved in community care that directly impacts their community, in that there needs to be “better linkages with health regions [and] health organizations to work with Aboriginal-run health programs to better integrate care” (p.20). Recommendations within the report were offered to meet escalating costs

and improve quality and efficiency issues as to provide better health services for Aboriginal peoples within rural and remote communities.

In providing further contextual background, Saskatchewan is a prairie province in Canada and has a population of 968 157 persons (Statistics Canada, 2006). Achieving provincial status in 1905, the province's name is derived from Cree and refers to the 'swift flowing river' depicting the Saskatchewan River (Hamilton, 1978). Saskatchewan has a 15% Aboriginal population, with 65% of its population being First Nations, 34% being Métis, and less than 1% being Inuit (Statistics Canada, 2007). In 2017, the Aboriginal population is expected to be 21%; a 6% increase over ten years (Dagnone, 2009). Saskatchewan has a strong Indigenous cultural and historical presence. For example, First Nations and Métis people from the prairies embraced the term 'Native' people with a "shared understanding of themselves as a cohesive Indigenous body in a common struggle against colonization" (LaRocque, 2010, p. 7). Indigenous scholars offered that the significance of the action demonstrated solidarity among the various cultural groups in moving towards an awareness of identity. However, one legal and cultural distinction among the Aboriginal population is that the federal government provided 'reservation' land for First Nations communities.

First Nations communities are often considered as 'on reserve' populations and are expected to grow from 60% in 2001 to 75% in 2021 (INAC, 2008). Reserve land is described as land that the federal government is responsible for, where funding for Band health care is provided through funding from the First Nations and Inuit Health Branch within Health Canada (Falk-Rafael & Coffey, 2005; Tookenay, 1996). According to transfer of funding agreements, local and provincial governments are not responsible for funding services for

Aboriginal peoples living 'on-reserve' land. Community services provided through transfer agreements to the Band for 'on reserve' populations include: health, education, and social services.

However, in relation to the jurisdictional debate as to who is responsible for services to Aboriginal peoples, the federal government is faced with the reality that Aboriginal peoples are migrating from the reserves to 'off reserves' or land that is under provincial and regional authority. Current trends in population statistics present that more Aboriginal peoples living 'on-reserve' are moving 'off-reserve'. For example, 60% of First Nations people live 'off-reserve' (INAC, 2008); a 20% increase from fifteen years ago. Jurisdictional arguments about jurisdictions are contributing to gaps in services, as well as do not reflect relevant and current trends affecting these population groups (Perisis et al., 2008).

As previously mentioned, the federal government has a responsibility to provide health care services to Aboriginal peoples that are fair and equitable, as well as to help improve relationships for a healthy and sustainable future. Seen through a critical lens, the demise of Aboriginal affairs is rooted in the *Indian Act* and within the historical colonial relation of the government not providing adequate resources to Aboriginal peoples (LaRocque, 2010). Under the Constitution, the federal government has legislation to govern over Aboriginal peoples without any recognition of self-determination or for self-governance (Government of Canada, 1982). The issue lends itself to a socio-political and economic debate of who is responsible for the delivery of health services if a First Nations person moves 'off the reserve.' Critiques of the *Indian Act* speak to the determination of

“identity and location, defining margins, and centres even within the Native community” (LaRocque, 2010, p.10).

The forced determination of Aboriginal identity can produce concerns of homogeneity, where the diversity of Aboriginal peoples is ignored in the delivery of health services. Drawing upon the social mandate for health, a call for action toward health equity is prevalent at a regional and national level by nursing stakeholders.

Recommendations from various stakeholders for meeting present gaps in health care delivery offered that health regions, provincial agencies, organizations, and First Nations communities partner together to improve the health of First Nations. Such partnerships would further help enhance the safety and effectiveness of health policies and programs with geographic rather than jurisdictional reach and impact (Dagnone, 2009; Senate Subcommittee on Population Health, 2009). For example, federal and provincial disputes, cultural barriers, and geographic isolation have impeded Aboriginal peoples from accessing the health care system (AFN, 2005; Lemchuk-Favel, 1995). With the pressing issues of patient dissatisfaction and high health disparities among Aboriginal peoples, conducting research in Northern Saskatchewan provided a rich environment to research how to help strengthen the relationship between nurses and Aboriginal patients, and to work towards addressing health inequities for Aboriginal peoples.

4.3.2 Local Context

The scope of the Northern health region included rural and remote health care services. More specifically, many of the nurses were experienced in working within remote, satellite communities where travel road access was limited. The research site included several nursing units: a rural-based hospital, primary health clinics, and remote nursing outpost stations. These locations were considered one of the largest settlements within the province for Aboriginal peoples. Within these communities, there was a high Aboriginal population (49%) as compared to the Aboriginal population residing in an urban centre (5%) (LHR, 2008).

This local community's history with European contact dates back to the early 1900s as a fur trading post between First Nations groups and European settlers. In an interview with the local tourism office (LTO) on November 2nd, 2011, the following was offered: prior to becoming a province in 1905, Saskatchewan specifically Northern Saskatchewan had a strong colonial history dating back to European explorers in the late 17th century and European settlement in the 18th century. The first settlement close to this community was established in 1770 (LTO, personal communication, November 2, 2011). In considering the historical context of the area and surrounding areas for its resources such as hunting and fishing, the community had a rich history of colonial relations between the European settlers and Indigenous groups.

Delivery of health services for these communities was under provincial jurisdiction and covered by one of Saskatchewan's thirteen health regions. This health region served one of the highest Aboriginal populations within the province. For example, the Aboriginal

identity within this health region comprised 81% of the population, which is relatively high compared to the province's capital health region, Regina Qu'Appelle Health Region, at 11% (Statistics Canada, 2007). The local health region was also the largest health region in Saskatchewan covering nearly 25% of the entire province and providing service to over 22 000 residents in Northeast of the province (LHR, 2011). Currently, the local health region is experiencing a high turnover of nursing staff, and difficulty retaining and recruiting qualified nurses within the communities (LHR, 2008).

This Northern health region was fully functioning with comprehensive programs including primary care to acute care services to continuing care and long-term care. Nurses and the management team (including the executive leadership team) were interviewed across disciplines including: emergency and acute care, public health nursing, primary health care, mental health, addictions, home care, and long-term care. A purposeful decision was made to include nurses from all the departments within the rural-based hospital, as well as primary health care nurses within the remote nursing outpost stations. Interviews with nurses and key informants from the various departments provided a broad community health assessment of the population served, and provided a full scope of the community health needs of the population. Research findings from the various departments providing community health services to residents of rural and remote settings can be applied to help strengthen the delivery and quality of health services for Aboriginal peoples.

4.4 Data Collection

This research study used primary data sources: interviews with twenty-five participants including frontline nurses, physicians, and regional health care administrators working within rural and remote communities in Northern Saskatchewan. The interviews were semi-guided with two foci that included participants describing their roles and challenges within their context setting, and identifying what organizational resources would be helpful in supporting them throughout their work. Interviews with other health care professionals such as physicians and administrators focused on their observation and analysis of nurses' roles and challenges within the communities, and what resources from their perspective would help nurses in delivering health services with relevant care to the communities. Please refer to Appendix A for a copy of the *semi-structured interview guide* that helped to facilitate the interviews.

The interviews were conducted over a period of one month. During this time, the participants were found to be forthcoming with their narratives, emotions, and perceptions of events. Interview sites consisted of the local hospital and primary health care facilities. Interviews were also conducted via videoconferencing for the satellite communities. Specifically, twenty-one of the interviews were conducted at the local hospital; two interviews were conducted at the local primary health care facility, and the remaining two interviews were conducted through videoconference at a nursing outpost station in Northern Saskatchewan. Each participant had separate interviews, and interviews ranged from sixty to ninety minutes long. All participants, with the exception of one, agreed to be audio-taped, and hand-written notes captured the interview without audio-consent.

The Principal Investigator was familiar with the working and living environment of the Northern setting, as she had previously resided in the community and remained in the community throughout the data collection. In this setting, the Principal Investigator had immersed herself in the Northern communities to optimize the natural setting of the nurses within their work and community environment.

In summary, data collection included conducting semi-structured interviews with twenty-five participants including nurses and key informants working within rural and remote Northern communities. All data collected were analyzed through CDA in exploring how nurses' roles and challenges are connected with racialized and socialized norms as presented within discursive practices.

4.5 Data Analysis

A key element of CDA is to critically examine the relationship between the 'social and the linguistics' within a textually based discourse analysis (Chouliaraki & Fairclough, 1999). CDA was used to analyze the interviews of nurses working within these communities, and helped explore how nurses' roles and challenges were embedded within racial and social underpinnings of how they viewed their 'Native' patients as 'Aboriginal' people.

Textual-data analyses from all of the interviews were analyzed through CDA to explore how nursing practice has been shaped by dominant discourses, and to help better understand the relationship between language and socio-political practices. The texts were analyzed at different levels of analysis moving from text's syntax to production to understanding including the micro-level, meso-level, and macro-level, respectively.

Within Fairclough's approach to CDA, there are three levels involved in textual analysis, in particular the socio-cultural level, the discourse practice level, and the textual level (Smith, 2007). Key phases of the textual analysis include a critical analysis of the context in which the text is produced, the textual techniques, and how the text shapes different practices (Crowe, 2005). These elements have also been referred to as analyses at the micro-level (text's syntax), meso-level (production and consumption), and macro-level (inter-textual understanding) (Smith, 2007; van Dijk, 1992). The different levels of textual analysis are utilized in developing knowledge to explore how language is a form of social practice rather than an individual activity (Fairclough, 1992).

Within this study, the nurses' roles and challenges of working within Northern communities was not viewed as an individual activity, rather, as a collective force in caring for their population of interest. In particular, CDA was used to explore how nurses' perceptions of Aboriginal peoples played a role within their nursing practice by analyzing the textual data for meanings related to socio-political and historical contexts embedded within their daily discourses. The deployment of CDA focused on critically analyzing the relationship between language and power in efforts to address complex societal health issues.

4.6 Ethical Considerations

In obtaining approval from the local health region's Research Ethics Boards [REB] to interview the participants, an application was submitted to the Population Health Unit in Northern Saskatchewan. The Population Health Unit in consultation with the local health region's Executive Team approved the application. Once community access was approved, it met part of the application for approval by the REB at the University of Ottawa. The research study was officially approved upon certification from the REB at the University of Ottawa, as attached in Appendix B. Once ethics approval was received from the University of Ottawa, the Principal Investigator consulted with the Director of the local health region to notify him of when the data collection would start.

Participants were aware that participation in the study was voluntary and that their signatures indicated that they were consenting to participate in the study. To safeguard the identity of the interview participants, all identifying information was removed from the transcripts and replaced with a unique code. A *Consent Form* (Appendix C) was given to all participants prior to their interview. All participants completed a consent form. In efforts to not interrupt the flow and functioning of the unit, interviews with participants were conducted on their own time. The consent form also described to participants how the data will be stored, as well as how confidentiality will be maintained during and after the research study.

Lastly, it is important to note that there was a wide range of participants that had taken part within this research study. Most of the participants including nurses, physicians, and regional health administrators working within rural and hospital based settings, also

worked within remote Northern sites. This lent to participants having rich knowledge and experiences about working within isolated Northern Canadian Aboriginal communities. As such, the participants easily discussed their nursing and health perspectives about Northern life.

4.6.1 Rigour

Considerations of rigour in interpreting the findings of this study can pertain to validity, transparency, and sensitivity. A limitation of the study is the initial assumption by the participants that the Primary Investigator was employed by the local health region, which, in turn, could have resulted in the inclusion of nurses and key informants apt to report their challenges in providing care to rural Northern and Aboriginal communities. Such deliberate openness to share experiences could thus have influenced the validity of the findings, either resulting in an over- and under-representation of perceptions and healthcare practices. However, the Principal Investigator being an outsider of the community could have further influenced the depth of revelations and interchanges.

There was a need to clearly articulate: the identity of the Principal Investigator as a researcher in nursing and health, as well as the purpose of the study to ensure that participants were well-informed as to whom and for what the information was being collected and utilized. Information was provided during the interviews as to the purpose and potential benefits of the research study. After the interviews, the participants' emotional experiences ranged from feeling relieved to being confessional-like, followed by a desire to improve their nursing practice. Each participant had an opportunity to debrief with

the Principal Investigator. As well, each interview was weighted equally for its contributions and insights to the roles and challenges of nurses working within rural Northern and Aboriginal communities.

Transparency may also be another limitation of the study. Research decisions must be made conscientiously to prevent and exclude research bias, as well as the potential influence of postcolonial theoretical underpinnings on the findings, as to improve the overall trustworthiness of the study. All nurses within the health region had an opportunity to partake in the research study. Each nurse that was interviewed identified a particular department as his or her home unit. In the end, there were a variety of participants and key informants including RNs, LPNs, and nursing managers that worked in several different departments. Please refer to Appendix D and E for *Demographic Information* of the participants within this research study.

The diversity of nursing practice, skill sets, and education offered the research study an ample view of what it was like for nurses to work within the community through various departments. This helped to eliminate biases in one particular area, as well as helped to develop a broad perspective of nurses' experiences of working in the North.

In addition to transparency, the interview material itself could have added to or constrained the sensitivity of the findings. Care must be taken to prevent marginalizing disadvantaged populations through research inquiry, but to enhance knowledge, practice, and community engagement and development. Specifically, the subject matter of the interviews was of a sensitive nature that could expose the vulnerability of the nurses as care providers, as well as the vulnerability of the clients who were dependent on the nurses for

delivery of health services. The common element of the vulnerability between the nurses and their clients was that they both were situated within isolated communities and surrounded or engulfed within desolate-like living conditions. Living and working within isolated Northern Canadian communities added an element of being alienated and secluded from the dominant society.

The main concern of isolation for the nurses was that they felt like they and their clients were external to the entry point of the health care system. This concern was addressed by nurses drawing upon what supports they wanted to receive from administrative stakeholders to help improve their nursing practice. During the interviews, participants had an opportunity to consider resources that could help them in delivering Northern health services to their communities of need. In turn, this helped the nurses to reflect upon the need for timely organizational resources in helping them to strengthen their practice with clients, families, and communities.

5. Results

*To write it, it took three months; to conceive it, three minutes;
[and] to collect the data in it, all my life.*

- F. Scott Fitzgerald

In total, twenty-four audio-recorded interviews were transcribed and with the written interview, all interviews were analyzed utilizing Critical Discourse Analysis. The method of Critical Discourse Analysis reaches beyond thematic analysis of qualitative research and moves towards understanding the power balance often represented by societal values through the use of language. Through Critical Discourse Analysis, four main themes were identified with sub-themes to follow within each theme. The four themes included: *Structural Health Care Systems, Public Portrayal of: 'Native' People and 'Native' Communities, Colonizing Nursing Practice, and Mobilizing Pathways in Aboriginal Health.* Please refer to Figure 1.1 for the *Summary of Major Themes* and Figure 1.2 for *Interview Themes and Sub-themes* of the Data Analysis. Following this, a synthesis of each theme and sub-theme is presented. The synthesis of each theme leads to a larger understanding of the roles and challenges of nurses working within rural Northern and Aboriginal communities influenced by postcolonial theory.



Figure 1.1:

Summary of Major Themes. © Zaida Rahaman, 2014

5.1 Structural Health Care Systems

The first theme, Structural Health Care Systems, speaks to the overall structure that nurses are working within, and how these structural systems shape practice on a daily basis. This theme is divided into three categories that include *Organizational Culture*, *Carrying Capacity*, and *Administrative Influence*. During the interviews, participants spoke about what motivated them in being a nurse and what lead them to working as a nurse within rural Northern and Aboriginal communities. Participants also spoke about what it is like for them to work in the North, and how some of the structures in place can sometimes create challenges for them in their day-to-day practice. Under Organizational Culture, the set of sub-themes included: *Motivation*, *Duties and Expectations*, and *Responsibilities*.

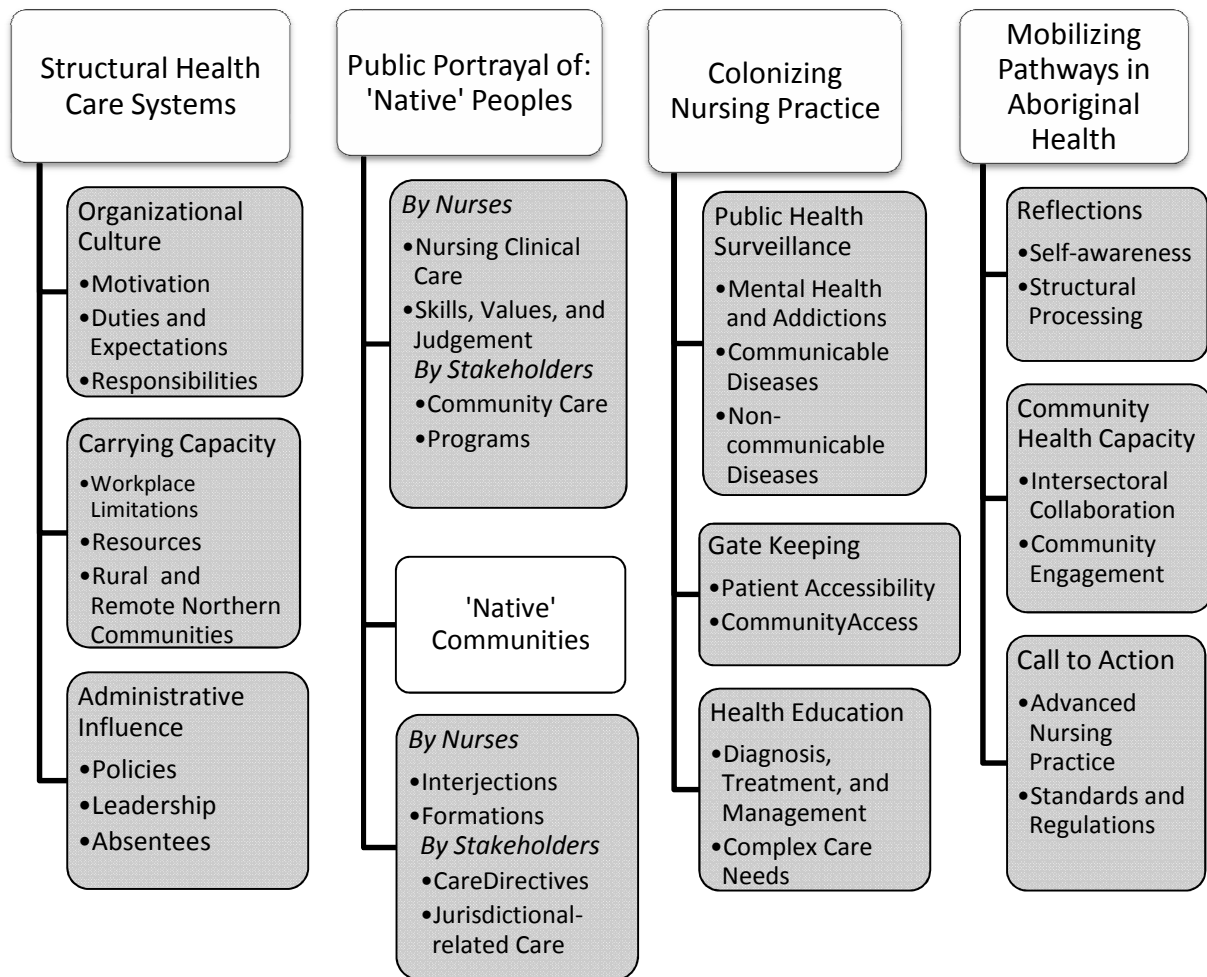


Figure 1.2:

Interview Themes and Sub-themes. © Zaida Rahaman, 2014

5.1.1 Organizational Culture

Motivation

Within the community, residents that were non-Aboriginal were able to access health care services provided by the local health district, whereas Band members living 'on reserve' land had to access health care services provided by the band. Some of the difficulty in providing health care services included not knowing who your population was, as well as not knowing what services are covered depending on your patient's location. The division of health care services covered by the health region and that of the Band, respectively, left a clear distinction that a patient was either part of the regular health region or of the 'Other'.

One participant described that when:

I was working with the band, I wanted to represent that we can do more with our life. (6: 125-127)

Working with the band left an impression that being associated with the band was a part of being the 'Other' or being 'Othered'. The participant wanted to advocate for the sense that their life as Aboriginal peoples had meaning.

The majority of the participants had different motivational reasons for being a nurse. Their motivation for entering the nursing field was more to contribute to the greater good of society. Examples illustrating this point were as followed:

Being a nurse, a large part of it is helping people. I do not think you go into nursing not wanting to help people. I think that is a large part of it is that you want to be there for someone whether it is because they are sick or maybe they are taking care of a sick person, like you are always just kind of in the caregiver role. (20: 190-194)

Well, you are going to graduate and you are going to end up with a job and it'll be a full time job and there would not be any worries with it and stuff. But, anyway, that is my education. And, while growing up at home, I had some younger siblings and I always looked after them. I like the nursing field. I like to be able to help people and look after people. (21: 12-15)

For these participants, the meaning of nursing was more focused on their need of wanting to be a nurse, rather than for the benefits of the recipients of nursing care. The focus of the motivation for the nurses seemed to centre more on his or her need of wanting to be a nurse, rather than on the outcomes or benefits of nursing.

Other participants focused on nursing as being a dynamic field that offered diversity within the profession. For example:

I am still learning lots. I am sure like a lot of the RN's (registered nurse) and LPN's (licensed practical nurse) that have been here for a lot of years go to conferences. And I go to a lot of those as well and get to learn new practices. It is also, like nursing is kind of one of those things where you are responsible for keeping yourself up to date with all the different practices and new approaches to different things. I find that that is always changing. Always learning new things. (7: 212-217)

For this participant, nursing was a dynamic field that offered many different experiences to keep up with. Nursing is not a static state of practice. Other participants offered that nursing is a profession related to service within health care, and that nursing can offer value to health promotion. They stated:

I went into the masters program, it was quite focused on determinants of health, and power, and equity, and I started to understand more that health was related to a lot to politics and it was related to the power that people had in their own lives. In

Nicaragua, there was a whole revolution that was kind of based around health care. When you started to look at it that way and participate in health as a movement, which I was able to do there, then, I think I kind of just transformed the way that I looked at things. I felt like, when you work in the community, you have a better chance to impact people's lives in a positive way. And I didn't feel like I was doing that in the hospital. (18: 74-83)

This participant saw nursing as an opportunity to help others within the health care field to elevate her patients' health status and improve their health outcomes. As presented, there were also participants who saw nursing as not being a balanced profession, such as:

My life is sort of geared towards work. I would say I work to live right now rather than live to work. I guess I work to live. Rather, than live to work. (24: 19-23)

At this point, the motivation for being a nurse varied in that nursing can offer diversity within its practice, varying from contributing to a caring profession to advocating for the 'Other' against society's mainstream view. One more perspective to add to the motivation of being a nurse included:

I grew up in the Southern prairies and I saw it as a way to go and explore the world and to work with other cultures, with other people and, I think I had sort of a 'missionary spirit' in me at that time. (17: 15-17)

This participant might have seen nursing in Northern Aboriginal communities as a continuation of missionary work. For example, nursing could be utilized as a provision of care to those whom are in need of care. Nursing care can have benefits to society at large.

Duties and Expectations

With being in the North, nurses often found themselves working without a script. For example, they did not often have the answers to questions, or know what day-to-day practice would bring. As stated:

I think it is harder now to describe exactly what I do with the community because I do not really have a direct kind of role anymore. It is more administrative now. A lot of it is in organizing, it is in talking to people who then talk to the community... and answer any questions that they have. (18: 151-155)

When we came up here, they needed somebody to start the volunteer program. So, I did that. Every role that I have had here with the North, I have always been in positions where I have had to start the programs from scratch. (14: 26-29)

For these participants, being in the North was like an adventure where nursing roles and duties were created in the field. There was no script to Northern nursing. As illustrated:

We are the forerunners when it comes to primary care. We are kind of the face of health care, I believe. (5: 27-29)

In contrast to the unknowing of nursing duties and expectations, some participants were able to clearly define their roles as to what they do. They stated:

My current role in the organization is being a community psychiatric nurse. I administer medication, injections. I offer advice regarding psychiatric medication. I do CBT, which is cognitive behavioural therapy. And support people with mild, moderate and severe mental health illnesses in the community. I also do suicide risk assessments downstairs. I'll also offer a psychiatric nursing assessment to the rest of my colleagues. (11:59-64)

I make sure all the communicable diseases are followed up or I send them off to the appropriate nurse, or a nurse practitioner,

or a physician to ensure that they are followed up including HIV and hepatitis C. (13: 89-91)

For these participants, their nursing duties and expectations were outlined specifically as to what they do, but without the consideration of the patient. Additionally, one nurse offered that she found her colleagues to be ambivalent within their nursing care to clients. For example:

Have you heard the phrase, 'not totally present?' I do not think the [nurses] are totally present (...) when they are providing the care. (6: 410-415)

Other participants offered that it was difficult to know what to do as lack of structural organization influenced their roles and create challenges within the workplace. One participant offered her experience of providing patient care when there was a lack of structural organization. For example:

I know the child's mom did not have anything. We had to beg and plead, that mom had extra at home to bring in and if she would've been on any specialty medication, we would not have had that and would not have been able to order it. She has a specialty bed which thank goodness they were able to find one in town, and we can borrow because she is from an out-of-town place. Thank goodness all of these things just fell into place otherwise, we are stuck caring for a child very ill-prepared. Right. How do you think that will be followed up? It would not be, very well. Because there are, so many chains of command and things get lost all of the time. (1: 102-111)

In this example, the participant offered that their duties and expectations including providing patient care could be forced upon them. In further analysis, nurses felt less 'stuck' in providing patient care if they felt more supported by their organization. The implied

meaning was nurses became resentful within their roles and duties without structural support from their workplace.

On the other hand, other participants offered that they welcomed their duties and expectations as part of being the 'softer' side of nursing. As illustrated:

Helping is the first thing. And, listening. I would say that being a nurse is having knowledge that is derived from experience, theory, and evidence (...) primarily, you are there to listen and help. As they want the information from you, then you give it to them, help them understand it. (9: 136-141)

It is about caring for people ultimately. Even though it is a very kind of scientific world now, I still think like the fundamentals of nursing are being with people, caring for people, suffering with people. And, advocating for people. (24: 45-48)

For some participants, the act of nursing created challenges that led towards feeling burdened as a caregiver. When the duties and expectations were unknown and even unclear, it was difficult for the participants to gain a sense of competency or understanding of success. Unclear duties and expectations led the participants to feel incompetent, which can further lead to poor work performance or suitability for the job. The following examples illustrated this point:

It seems like people just, they cope and they cope, and then, at some point, they just snap. [Emphasis added] I snapped. I have seen a lot of nurses snap. You have to reset and just, you know, go back. I just let it all get to me. I got frustrated and angry and pissed off and eventually, I snapped. I took some time away and I came back fresh and new. And I know I could not last here doing that. It is too frustrating, you know. Nothing changes, it is too slow. I really do not think this is a good province to come work as a nurse in. (24: 426-439)

If I think back to, as a manager, my challenges were getting the right people in for the job. People who had the right attitude of understanding the basis of what the problems were, what caused people's health problems, and, what were the influencing factors. But also, if that went too far, then you found you had a nurse who tried too hard to fix everybody. And so, then, you'd have a nurse who was burned out and tired. [Laughs] So, having a realistic sense of self and what your job could be and where You have got to say, "I cannot do this, this is somebody else's responsibility. (25: 271-277)

From the participants' reflections on their duties and expectations of work, their message communicated that it was frustrating and challenging to wait for change. Furthermore, this contributed to the participants feeling deflated within their workplace in that what they were doing may have no or minimal impact.

Responsibilities

The perception of nurses feeling responsible for providing nursing care to their health region was extended to feeling responsible for the other two regional Northern health districts. Within the province, there are thirteen health districts. Geographically, the health district that the nurses were a part of was considered one of the central locations for the North as it was located in a main city before travel access became limited. The location of the nurses' workplace added to the burden of nurses feeling like they were in charge of coordinating services for the North. This led the nurses to feeling that they were not only responsible for their specific community, but for all the Northern communities within the province. Each health district comprises of eight to ten communities that are predominately remote communities with a high Aboriginal population. Services for these

communities were provided by regional health services and by the Band for 'on-reserve' communities.

Specifically, it was challenging for nurses to understand what their roles and duties were when they had such a large scope of population to work with, as well as not having the accurate level of communication needed for their positions. For example:

In this role, because I am working with the three health regions, I feel I need to be confident and knowledgeable with my practice and be able make sure I know where to look for the proper information if I do not know it. I think I need to have a positive attitude and open communication. Definitely, good communication is key to this position, because there are so many individuals involved with my work. (13: 210-214)

In this example, the participant described the benefits of open communication within practice and for her patients.

Participants also offered that inherent nursing responsibilities meant caring for their patients as well as communities. The caring side of nursing seemed to be more of what they expected nursing to mean, but also on the other hand, they did not realize the magnitude of the role of caring for the Northern communities. Further analysis offered that being a caregiver did not necessarily have any built in evaluation tools to know when their role and responsibilities were completed. For example:

Being an advocate, determining how you can be an advocate for a patient who might come through a door, it is a huge role. Being compassionate, sometimes, there is not a lot that really is wrong, but you need to be somebody who cares and the patient needs to feel cared for. And that can take on so many different faces. You have to be understanding. (5: 63-67)

I think being a nurse is someone who in a small community is someone who people can stop and ask you on the street questions about health related issues that they may be having at that time. And, it is just a unique circumstance. I mean, I do not know that you would get that in the cities. I have lived here all my life. (4: 51-57)

Being a community health nurse was a role many of the participants seemed to be comfortable with in working within their local community. However, there also seemed to be a naivety that was often embedded within the scope of community nursing. As illustrated:

Community nursing is working with people to improve their health, preventing illness. And that is something I have always said as well is when people say, 'Well, what do you do?' I say, 'Well, instead of fixing sick people, I prevent people from becoming sick or unwell.' (20: 212-215)

With harm reduction, I do a lot with harm reduction. So, preventing, for example, with needle exchange program, by giving the clean needles, preventing them from spreading disease such as HIV, and hepatitis C. (20: 222-224)

In these examples, the participant recounted their roles and responsibilities as matter of fact as if they had no conviction or meaning within their role. The participants also offered that nursing can be mechanical. Through Critical Discourse Analysis, the employment of population health strategies such as harm reduction might not be effective if there is no 'associated meaning' or relatability to the population that the nurses were working with. The lack of relatability of nurses to their population was challenging for nurses in trying to understand what their patients needed, and how to best serve their population health needs.

Similar to the other interviews, there were more examples from participants that demonstrated that nursing within the North encompassed many roles that were seen as formal

or informal. Formal roles were often described as what the nurses knew they needed to do; whereas informal roles were described as responsibilities that were learned along the way through practice. For example:

Here you deal with everything so you are kind of like a jack of all trades and master of none in a sense and I think the nursing staff can struggle with that phenomenon as well. I have noticed we tend to see more new graduates that come to sites in the North. We are supposed to have nurse practitioners practising in our outposts, but the fact of the matter is that we do not actually have. (10: 160-169)

My current role is as a primary care nurse. And my role includes everything from home care to emergency nurse. It is everything, really, the list goes on. I do everything from we take care of emergencies. We do home care. We do chronic disease. We do follow up. I assist with the Public Health nurse. I do not do the immunization part, but like flu season, I do immunizations. We do blood work, lab work, lab reviews. We do community development, teaching out in the community. (23: 30-39)

Through the interview with the nurses, there was an impression that some of the participants had a humorous way of describing their responsibilities. Their approach to describing their duties and roles seemed to be a tool in coping with their large scope of responsibilities. As stated:

I put everything from like being: a nurse to a pharmacy tech, to a clerical staff, to a babysitter, to an educator, to EMS [Emergency Medical Services] personnel, administrator, manager, caregiver, respite person, computer technician, doctor, taxi driver, emergency coordinator, a building maintenance manager. (24: 84-87)

But a nurse in Northern Saskatchewan, a clinical nurse and even as a manager, you were a counsellor, a social worker, an

educator. You were a person that was seen many times to have authority that you really didn't want, who gets to go to, you know, on the taxi for an appointment and stuff like that. That was the worst part of it. [Laughs] You were seen as a gate keeper. And I hated that part of it. A gatekeeper to other services. (25: 56-62)

In the last example, the participant's expression of her roles and responsibilities exemplified how her staff had felt about their wide scope of practice, for not only to their specific community, but also to the North in general. This responsibility was overwhelming in not knowing what the scope of their practice was, as well as how their scope of practice could be measured and evaluated. Without having a formal sense of their roles and responsibilities, it was difficult for nurses to feel like they were accomplishing their roles and duties. The sense of deciding who gets care or who does not contributed to nurses' stress of feeling like a gatekeeper, which led to further feelings of caregiver burden.

5.1.2 Carrying Capacity

Workplace Limitations

In building upon the aforementioned statements, unknown and unclear responsibilities can create challenges within the workplace for nurses working in the North. Specifically, it was difficult for nurses when they were unclear of their responsibilities and duties.

I think it is challenging to be put in a role where you are not sure what your responsibility is. You are not sure what it is going to look like, and what you are going to be doing. (18: 350-352)

As one nursing student expressed, she said, "I feel like I am kind of an outsider when I come in the room with you, because you already sort of know who this person is." (20: 394-396)

Additionally, the uncertainty of nurses' roles was further compounded by them not feeling like they knew the patient, or well received by the patients. Feeling like an outsider was a challenge for nurses. For example, the above participant did not feel like she could relate to her patients, which contributed to a further distance between the nurse and the patient.

Participants also contended that it could be a workplace limitation to not know their patient's history. A patient's history and information is a necessary resource for nurses in being able to provide safe and effective care for their patients. For example:

We do not know any patient history of theirs while they are in detoxification or mental health, we do not get that information. (1: 275-276)

Another barrier to obtaining current information relevant to patient care included viewing the patients themselves as a source of information, and not being able to understand what their patients needed. As described:

It is hard to try and understand what somebody wants when you cannot understand what they are saying. You need to kind of try to work with people and implement new ways of communication. (7: 372-374)

When information about the patient was not communicated effectively, it posed significant challenges for nurses in being able to provide safe and effective health care services for their patients. The lack of information created challenges such as misunderstanding information or making assumptions about care. Assumptions and generalizations were challenging as they created an environment where care was not provided on a substantial basis. The difficulty in addressing this challenge is how nurses can engage with their patients and making patients feel comfortable to share their information.

Other challenges that nurses experienced in the workplace included that it was difficult to access or use resources correctly. Suitability of resources often required assessment and evaluation of the resources to assess the purpose and evaluate the outcomes. The challenge within the workplace was that resources were not frequently assessed or well publicized. For example:

There are many resources that are already available, but not always utilized. An example would be most of the outpost and the hospital here have online resources like Up-to-date for reference use, I know that the nurses received grants for continued medical education that they used for devices like iPhones and iPads. Although I think a lot of them bought them, I do not actually see them using them frequently. (10: 534-542)

In addition to not understanding what the resources were used for, it was also difficult for nurses to remember to use the resources for patient care when they were used infrequently.

As described:

Our workloads right now are really hard to manage. I would like to see my clients more, have that time to call more people. Even just a follow up call, sometimes it is all you need. It is just to touch base with them and they usually have a few things to say here or want to book an appointment. (12: 299-306)

This example speaks to nursing care as being a practice of habit. It was difficult to introduce change when nursing care was often engrained in a routine practice. On a larger scale, it was difficult to provide safe and effective care when nurses felt like they were not being supported by their workplace. Specifically, lack of staff or inappropriate staffing created a workplace limitation to providing patient-centred care, as illustrated by the following:

The challenges I face, we do not have enough staff. We have a lot of clients. We are growing, and growing, and growing. Our region has not kept up to that growth. (14: 386-387)

Other structural resources created challenges within the workplace such as clients not feeling welcomed to access health care services or not being aware of how to access care. For instance:

Clients would call because they want an appointment. They sit in the waiting room and then, they come into the clinic room. I come in the room and say, "Why are you here?" (...) They just do not feel well. So, you do a physical exam and talk about doing some blood work and maybe do a little bit if we can here in our lab and can diagnose diabetes, because their sugar is high (...) You then set up a follow-up time. But there is a lot of time constrained around that, if they just booked in for dizziness, then, they only get 10 or 15 minutes. (9: 148-173)

The following example also describes how time or the lack of time was a workplace limitation that can impact the quality of patient care. Specifically, the lack of time highlighted the issue of nurses having limited time with each patient, and how that limited time could impact the quality of patient care. As stated:

To get somebody to be seen or followed up, it is a process. It takes a long time. For one patient, it might take me a week to put a chart away. My desk is always full of charts incomplete. You have a lot of a lot of things on your mind (...) There are patients that are waiting on the waiting list who need to be seen. And some people are impatient. Some people, they cannot afford their medication. Some people, they miss their doctor appointments. (23: 253-261)

In this example, a workplace limitation was that the current system of seeing patients did not allow for flexibility. In an environment where travel can be limited and flexibility with

appointments was sometimes a necessity, inflexibility posed a workplace limitation in delivering Northern health services.

In addition to the structural workplace limitations, there was also a practical or operational element to the workplace limitations for nurses to perform at an optimal level within practice. Some of these factors were analyzed to be relational. As illustrated by the following:

A lot of nurses [are] unwilling to work with other nurses. This is a challenge. It is not constant and it is not everywhere you go, but especially like the ready to retire generation of nurses compared to the newer generation of nurses. The ready to retire do not want to see any kind of change. If you try to be more evidence based in nature, which is what RNs and LPNs should be, there is like a fight from them to change their practice, regardless of what it is. A simple example would be they no longer advocate the chevron taping method unless you have sterile tape. RNs refuse to change that method because that is the way they have always done it and that is the way they are going to do it. (5: 275-283)

Nursing is a profession where there was often a mix of junior and senior nurses within practice.

Without mentorship from senior nurses, it was a challenge for junior nurses to feel included within their workplace. Another example illustrating relational issues included:

There are many issues in nursing, for example: bullying, oppression, lack of orientation, poor retention, and poor recruitment. Power comes with time. It is time to see your profession. (8: 37-42)

As evident from the interviews, working in the North was challenging due to unclear roles and responsibilities and numerous workplace limitations. Another consideration of workplace limitations was also related to the population the nurses were caring for within their

practice. Working in the North, nurses tended to be exposed to patients and families that have experienced and suffered many traumatic life experiences. For example:

Lots of the time, we are soaking up, we are almost a sponge for people's traumatic life events. Some people have had terribly horrible experiences. When you are sitting there with a child, or a young adult, or an adult, and you are trying to get this information out from them and they tell you about what happened, if I didn't have a way of dealing with that, then, I would not last very long in this job. (11: 12-125)

Being exposed to their patients' various traumatic experiences was a challenge for the nurses to cope with on a daily basis. This was also in conjunction with the trauma and violence that nurses might experience from their patients. As illustrated:

We are getting some clients that are physically, verbally aggressive, violent. We have some on long term care. Some of the girls (the nurses) have been struck or hit, that kind of thing. So, that is not with any injuries that they are off work, but they may end up with bruises and things like that. (21: 384-387)

The participants did not feel like they were able to protect themselves from their clients or that they were in control of the situation. In further analysis, participants felt like they were at the mercy of their organization in terms of their own mental health and physical safety. As illustrated from the following examples:

We just take a look at people and we say, "Yes, they can do the job. They have got the credential. We will put them out here and let them work. If they burn out, well, then, we will bring in another person to do the job." And it is not, you know, that callous. (22: 238-241)

I have seen nurses who, you know, myself included at times, came through a terrible tragedy, clinical tragedy that they felt incompetent to handle, but we put them there with one or two

other people. And, long behold, accidents happen and somebody's lost and what do you do? You know. You have got nobody to beat up but yourself. And that was the thing that you really had to support people from, because those things would happen through no fault of the nurse, but through the fault the event itself, circumstances. (25: 147-153)

Through Critical Discourse Analysis, having the expectation that nurses are to endure workplace limitations can be considered a form of violence, expecting that nurses can or should survive their current circumstances. However, nursing is a humanistic health industry serviced by humans to humans. In support of improving nursing conditions and practice within Northern communities, a critical analysis of workplace limitations is necessary in working towards better conditions for nurses, as well as for the benefits of their patients and population of care.

Resources

As part of the organizational structure of the health region, resources can play a large role in how the organization functions and performs in providing health care services to its clientele. As similar to other health regions, it was evident that nurses within the Northern communities were considered as part of human resources. However, the value of the resources was subjective and its inherent meaning varied based on the evaluation criteria. Within this section, the various resources such as nurses and their knowledge are further explored through CDA. For example:

I know where to get all my information from and stuff, like I use a lot of Internet sources, the Saskatchewan Health. (12: 143-144)

They (the senior nurses) are very confident, but they are not always necessarily as patient with younger, new graduates, not always as willing to be mentors or teach, in part their knowledge that they have to their other staff members. I am not entirely sure why that is, maybe it is a cultural that that is how it was when they went through. In medicine for physicians at one time it was like that as well, you did that because that is how it is always been. (10: 479-484)

In the North, training younger nurses was a challenge if the nurses were not willing to share their knowledge or expertise. This created a challenge in creating a workplace environment where visible divisions of experience and knowledge were easily palpable by the staff.

Valuable resources within nursing also included specialized nursing practice. Within the North, it was difficult to retain and recruit nursing expertise within an area of speciality.

For example:

There is no such thing as nurse practitioner in psychiatry in Saskatchewan. It is a terrible shame, because it would benefit the local community hugely if nurses of higher education were able to diagnose and prescribe. There is a huge lack of psychiatry here. And if they had specialists in psychiatry, it would just benefit the local community massively. (11: 14-20)

With a lack of mentoring, it was challenging for nurses to rely on existing knowledge without having a solid foundation of knowledge to build upon. As argued:

I have had to be independent in this role, because it was new. There was nothing to go from. Being kind of that outgoing independent person where you are not afraid to ask questions, you can make some phone calls and seek out other professionals. (20: 317-320)

Additionally, another resource that participants struggled with throughout their practice was time, or the lack of time. For the participants, time was a valuable resource,

further compounded by not having the appropriate technological resources. In the following example, the participant described that time, technology, and knowledge were integral in being able to provide services to their clients. This lack of resources created challenges and contributed to an environment where nurses provided less than optimal care. For example:

(1) First is time. There is not enough time; and (2) we do not have appropriate technology. We do not have appropriate interdisciplinary collaboration. We do not have enough of the interdisciplinary collaboration. Let's say I need a diabetic educator or social worker, they are there, but the problem is they do not live here. (23: 243-250)

Without having local community knowledge, nurses were not in the best position to provide optimal care to their clients. Managers and key informants also expressed how the lack of local community knowledge and resources can impact the quality and delivery of patient care and nursing practice as a whole. For instance:

In hiring, I cannot find the best match, I have to hire. There is no pool of applicants to choose from. This affects patient care, usage of best practice, and research. It is like a 'war'. If I go into the 'war' with good equipment, and the army is good, we win the 'war'. If we go into war, and see what happens. You are as good as your team. (8: 91-97)

Utilizing the analogy of staffing nursing care in the North was 'like a war' drew parallel to the notion that nurses can be used as resources to best situate one's position to shape the desirable outcome. In this example, nurses were seen as resources to position the health region to be in control of the outcomes.

Similarly, other resources in situating the health region in a favourable position included having the appropriate equipment and providing resources needed for patient care. As illustrated by the following examples:

We have an ambulance, but it does not work. Let's say something happen in the plain desert land and we need to drive this vehicle out, it just does not work. And we have complained and complained for the last four years. (23: 355-361)

If you had a hospital that had 10 IV pumps, right? You are not going to have all 10 of those IV pumps old and outdated and not really working very good. You might have one, right? Well, we only have one IV pump. [Emphasis added] We should have the top best IV pump, as far as I am concerned. If you want to make this a good environment for people who work, we should be a priority as far as equipment and up to date standards, you know. There is no reason we should have anything below standard here. (24: 253-261)

Critically speaking, having equipment that was not appropriate for care created an environment where health care providers were not responsive to the needs of their clientele. This contributed to nurses feeling like they lost the 'war' before they even fought, as they felt like they were not properly equipped to care for their population.

Within the workplace, nurses also needed to understand how social and political historical contexts related to colonization can impact their patients' health and health outcomes. For example:

Our clientele are treaties so they are not expected to transport themselves down for tests, they get it all paid for and stuff. That is frustrating. [Emphasis added] Just because you see where a lot of taxpayers' money goes for transportation for clients. Even the ambulance, they do not pay for ambulance

anywhere. I find that frustrating, only because I find that it is abused quite often. (2: 347-353)

With a lack of local community knowledge such as Treaty Rights, it was difficult for nurses to provide health care services to their clienteles objectively and without judgement. On the other hand, nurses also became detached from their clientele as if they were faceless. For example:

We have thirty-two clients on the waiting list to come in. We do not even look at the names when the applications come in. We look at the number and the condition and what their issues are and how bad they are. It could be someone that is only been on the list for a couple of weeks as opposed to someone that is been there for a couple of years. But that is someone that is been there for a couple of weeks, lived on the street or is going from home, to home, to home, to home and does not have anything. Whereas the one for a couple of years, well, lives at home or is in another facility waiting to transfer here. (16: 659-670)

In providing responsive care to their patients, it was helpful for nurses to understand the living conditions of their patients and how these various social determinants of health might impact their patients' health outcomes. With a lack of community knowledge, it was challenging for nurses to feel connected with their patients. The community knowledge of living and working in the North is an essential part of helping nurses feel connected to their patients and communities.

Rural and Remote Northern Communities

Similar to workplace limitations and resources, working within rural and remote Northern Canadian Aboriginal communities added stressors related to the environmental landscape

of the carrying capacity within the North. Carrying capacity speaks to the limitations that the nurses experienced on a daily basis, but also contributed to the bigger context of population health within the region over time. This idea of carrying capacity referred to the long-term impact of limited resources from current issues within the structural system. In essence, carrying capacity speaks to the long-lasting damages of present day health issues. Many of the nurses faced challenges on a daily basis that were part of the structural system of delivering Northern health services. These challenges were often unique to the Northern landscape in providing care for a large geographic area. For instance:

Some of the challenges come from the uniqueness of the North and that we are sparsely populated, we are spread out half of the geographic population for maybe 3% of the population. In order to deliver services to go and support staff, a lot of our time is spent travelling. (17: 389-392)

There is a lot of difference in terms of mobility in the North than there is in the South. We have our distances, obviously, but even in communities there are fewer people who have access to transportation. Particularly with elders, if they are living on reserve, they have a difficult time travelling to a facility. The cost of a taxi is extremely high so that also presents a challenge. (22: 156-163)

The responsibility of providing Northern nursing care to a population that covers a vast geographic landscape was challenging. With Northern nursing, there were challenges not only with mobility as compared to other parts of the province such as Central and Southern health regions, but also with isolation that is familiar to Northern living. Specifically, isolation associated with living in small rural communities limited patients' access to timely care. As illustrated by the following quote:

One of the challenges has to do with isolation. And then, there is, you know, trying to gain access into communities that are very closed. If you come from another area, if you come from the South or you come from another, you know, province and you come into one of the smaller or more remote communities, then, it is very difficult at times to negotiate entry in a meaningful way. (22: 202-208)

In delivering Northern health services, there was a greater pressure felt by the nurses to be additionally qualified, as compared to other areas of the province. Nurses were treating patients and complex care cases that usually required advanced nursing practice. Furthermore, the state of patients' health was often in progressive conditions of illnesses and diseases. As illustrated:

It becomes a lot more important to have additional training for those nurses. For physicians for instance, we can practice with just our degree. We do not have to have to have other kind of completion of educational courses other than our ACLS (Advanced Cardiac Life Support), because we deal with cardiac patients in the hospital, we have to. (10: 52-56)

Every patient is different. Every day, you see something different that you have not seen the day before or like a different condition that you might not have seen before. And then you learn about it and how to treat it, and what their needs are. So, I just find that you do not really see every condition. It is kind of spread out. (7: 194-203)

From these interview excerpts, participants described that one's knowledge and nursing practice needed to be advanced in order to survive the elements of Northern living. Through CDA, the concept of surviving in the North referred to working within isolated conditions and working with a clientele that had advanced stages of diseases. An additional example included:

Let's say we have somebody's sick who live far away, they need an X-ray or they need dental care. They have to go, drive themselves to or find a ride to go all the way to the city. And then, because of sometimes of course they delay that. They miss [their] appointment because they cannot afford it. What will happen is that a simple dental procedure now becomes a dental abscess. (23: 230-235)

The geographic isolation within rural Northern nursing posed an ethical health challenge to advancing the stages of illness without proper resources, but was also challenging for nurses in responding to a deteriorating health status that could have been avoided with the proper resources. Additionally, in working in rural Northern communities, nurses were also living in communities that they were not familiar with, nor comfortable with. For example:

I see that Northern communities, and I do not see how they [nurses] develop a bond with the people there so that you really get to know people, but, unless you buy groceries at the same store as they do, pay the same prices that they do, suffer the same shortages that they do, you do not really always understand. And, yet, the nurse will always go home to a nicer home, you know. She'll be one of the highest paid people in that community, if not the highest paid. So, it is easy to be very superficial now, I think, whereas years ago it was not. You were forced to be part of that community. (25: 161-167)

Living in rural and remote Northern communities was difficult for nurses to feel like they were welcomed by the community. Without having a connection to the community, nursing care was not a welcomed asset to the community and was almost seen as an intrusion to community life. In this light, uninvited nursing care was viewed as an extension of colonizing practices over the communities. As illustrated:

One of the things that really stand out for me is with the community, especially a small community; it takes a long time to

gain their trust. So, I always think, "Do not give up, keep trying, because it may take six months to a year to actually develop what you want in a community and get that rapport with the community members." (20: 42-45)

To further elaborate on this point, nurses in the North were viewed as uninvited visitors that provided health care services to communities in need of essential health services. Conversely, nurses that were not familiar with the Northern communities could hear stories about what their communities were like. These stories whether true or false were often taken as being valid or true without verifying the facts. As stated:

At times, we do not appreciate or we underestimate the effect that working in small remote Northern communities can have on a person. As, you know, the school systems can be really challenging. So, if a nurse comes in and she's got a family and she tries to bring him into an educational system where you have a school which is like a jail, like, they have got bars that they move on towards them, slams these bars open and those bars open to herd kids from one room to another. It can be quite challenging. (22: 241-247)

From this participant's quote, the nurse expressed that working in rural Northern communities was an experience of endurance and hardship. Their quote further speaks to the intention that nurses were not working in the communities for the benefit of the community, but for themselves and their own outcomes; otherwise, they would not be there. Furthermore, nursing was described as a means to making an income where they were substantially paid more than their counterparts in the central or southern parts of the province. However, nurses have the advantage of making false assumptions about their patients, as their health or life is not dependant on the delivery of essential health services as it is to patients and communities.

To paraphrase one of the managers, nurses can afford to be 'callous' with their patient care, as nursing care does not affect their own health status.

5.1.3 Administrative Influence

The last theme under Structural Health Care Systems was *Administrative Influence*. This theme was a follow up to the other two themes *Organizational Culture*, and *Carrying Capacity*. Within Administrative Influence, there were three sub-themes: *Policies*, *Leadership*, and *Absentees*. Each of these sub-themes influenced nurses' working milieu, creating challenges within practice and receipt of relevant care. The first theme was Policies. The primary consensus among the participants was that policies played an important role in governing their practice; however, these were rarely used within practice.

Policies

During the data collection, participants from various departments such as emergency, long-term care, public health, and community health were interviewed for this research study. Within the emergency and long-term care departments, participants spoke about how their experiences of violence from patients were a part of their working environment as if it was part of the norm. One participant spoke about the need for having policies specifically around the following:

Hire security. We need it more. I do not like policies. But they are necessary. We have a zero tolerance policy. It does not work, but at least we have it. (3: 128-130)

Another participant identified that policies were not helpful when they were not implemented or adhered to within the workplace. The lack of adherence to policies created a structural environment that did not necessarily promote respect for the patients in need of essential health care services. As demonstrated:

You can have all the policies in the world that you want, if nobody reads them and nobody adheres to them, you might as well roll them up and use them as fire starter. Right? So, it is only as good as the paper it is written on sometimes. (21: 768-770)

Specifically, policies were helpful in maintaining the flow of a system; however, policies as a resource tool needed to be managed and evaluated for effectiveness and efficiency. For example:

I think we need to write some policies. I think what we do evolve and changes all the time. But, policies tend not to follow. If we are called on it, then, I think for our own protection, we need to have some of those policies developed, written to support what we do and to protect us as employees. (4: 658-663)

From this example, policies needed to be reflective of the current practices and needs in order to meet the demands of the workplace. Within their nursing practice, participants spoke about policies that were difficult to maintain, as there was such a high turnover of staff, particularly of management. Furthermore when policies become dormant, it was difficult to create change, specifically if progress needed to be measured or documented. As stated:

The *Mental Health Act* has not been reviewed since 1988 in Saskatchewan. We are currently as a province reviewing it and looking at some revision, so that we can better integrate our addictions and mental health services. (22: 44-47)

It was difficult to measure change within an organization when the status quo was not measured or used as a reference. For example:

We have just some internal policies that we are working on. Over the many years before I came to this position that stuff was just done because that is the way you did it, things, in a lot of follow up or just the procedural of follow-up has never been documented. So, that is been a challenge that we've been working on just documenting. (13: 548-552)

Policies that captured the strategic layout of the organization were helpful in moving forward the organization towards achieving its mission and values. However, when the policies were not well documented or appreciated within the organizational culture, policies were considered as a hindrance or a barrier to the employee's duties.

In practice, policies were also considered as a challenge for nurses to follow when difficult to implement. For example, changes in practice that went against the status quo were difficult to initiate within the workplace. The following example illustrated how the implementation of public policy can be difficult to initiate, as it created a new behaviour or manner of action. As the manager explains:

We had a policy at our health centre in our region that there is no smoking on the property. That is a public policy . But is it an easy one? Accept the fact that people smoke and give them a place to go smoke where it is not going to bother other people. Help them to quit if they can. But, if they are not going to do that right now, that is an example of a public policy . That is a healthy regional policy that stops a little bit short of where it should be. (25: 580-593)

From the above example, policies can have a positive contribution to health promotion if they are implemented in collaboration with patients and communities. The

implementation of policies can be specific to health units; however, it was difficult for frontline staff to see how policies at a provincial level can relate to current practices. Specifically, the development of policies was often seen as irrelevant to current practice as it was difficult to see the connection between the two. The following examples illustrated how policies were difficult to implement when the nurses did not see the link between the benefits of policies to patients' health outcomes. Furthermore, policies can act as barriers in providing care to patients in need of essential health care services as they can create barriers of social exclusion to care. As elaborated:

Patterns of drug use specifically the choice of drugs for opiates are morphine, we do not have heroin in the community. The drug of choice for stimulants is actually cocaine and in the past few months there is been a large infusion of large volume of cocaine. Unfortunately, some of my addiction patients have relapsed. There is a lot of marijuana use, but when I see a patient with major addiction to alcohol or injection drug problems I treat those first before moving on to the marijuana. (10: 278-284)

We do run into some difficulty given that mental health is covered by the *Mental Health Act* in Saskatchewan and addiction services is covered by the *Freedom of Information Act*. When it comes to looking at each other's files and, in some respects, the disclosure of some of the issues that are going on for clients, the acts in themselves prevent us from being able to share as openly as we would like to. (22: 39-43)

Policies within the workplace were challenging to implement, however, policies can be useful in guiding the staff to provide a high quality of health services delivery to their patients. This was a challenge to accomplish when there was diminished or minimal leadership to oversee that policies were followed within the workplace.

Leadership

During the interviews, managers and personnel from the regional administration team were interviewed about what they saw as the roles and challenges of nurses in the North. Before they offered their observations of challenges, they described what they thought was their vision for leadership in the delivery of health services to Aboriginal peoples. For example, within the delivery of mental health services:

We can offer the best quality service that we can. We can offer safe advice. We can access mental health services in different areas should the need be. We can treat people with respect and dignity. (11: 286-288)

Managers also offered how difficult it was for them to manage their various divisions within their portfolio, with sometimes different and competing priorities. In particular, one manager described their position as being political and challenging to lead a team where leadership was not seamless throughout the organization. As offered:

I am in the hot chair. It is political, linked to the front care, dealing with patient care. I have five directors, and I am networking with other stakeholders. My instructions need to be clear. Issues oriented. Not people focused. I need to give staff feedback. For example, change of practice, nurses are resisting education, i.e. infection control, i.e. they are not taking a course. I need to go to the front-line and find out what is going on. For example, the workload. I want to know the reason behind the resistance for change. (8: 57-67)

The impact of inconsistent leadership throughout the organization created a sense of disharmony within the delivery and quality of health services. For example, one manager was frustrated that the delivery of home care services was not a priority for the organization; despite, the demand for increased services within this area of care. As described:

Senior leadership has not paid enough attention to home care. They were not listening. We kept saying: "This is what is happening. Our future is changing. It is community care." You need to put the financial and the human resources into this program. Now, of course, we are in a crisis. I always get tired. They do not know what to do with us. (14: 390-396)

The above participant expressed that she needed support from her management team, not only for resources, but also for direction relating to programs and services.

Another employee offered that she needed management to help advocate for more staffing in helping to win the 'war.' For example:

To be really broad about it, I focused on the needs of Public Health than our clients. I mean to say that more staff would be great. I am sure a lot of people will say that. (12: 431-434)

On a daily basis, it was challenging for nurses to feel supported when they felt that there was a void in leadership from their management team. The following participant described her feelings of working in a health region known across the province for its difficulty in retaining and recruiting nurse managers. The nurses felt like they were abandoned when many of the leadership positions were unfilled for several years on end. In further description:

These positions have been posted for a long time, and they had interviews and they have accepted people. Then people do not end up coming through on the deal. And I do not know if they have turned people away, I do not know. I just know that they have been available and vacant for too long. Like who has no director of nursing on a hospital for years that is open and vacant? Who has that? I do not know if there is not enough incentive for people to want to come here or what the issue is. (1: 406-412)

Through Critical Discourse Analysis, the underlying tension that the staff felt was evident within the workplace. With continuous lack of leadership from administrative staff for several years, the nurses started to internalize their feelings of being forgotten about, as it was part of the norm of working with Aboriginal peoples. During some of the interviews, specifically in departments where there was no management or leadership, staff expressed feelings of despair, anger, and frustration for working with patients that do not change their health behaviours. Feeling powerless to create change, staff seemed to transfer their feelings of despair and frustration onto their clients. In this act of transfer, nurses found a way to cope with their anger, and gain a sense of control over their working environment.

Absentees

Within the structural system of the health care region, absenteeism in management and effective leadership was identified as a factor affecting the nurses' duties and roles in caring for their clientele. Specifically, nurses providing day-to-day care for their patients felt the impact. In particular, nurses throughout the organization were frustrated with the lack of management to oversee care from one department to another, as many departments did not have a manager. One nurse stated:

We have not had a consistent Director of Nursing for the last seven years. There has been a huge turnover in that position. It is hard to provide a lot of structure, education, and expectations for nursing staff when you do not have a good leader at the helm. The same thing happens in the outposts as well. I do not know how they determine who the Directors of Nursing truly are. You got the shortest stick; you are the director of nursing. [Emphasis added] [Laughs] (10: 627-640)

Participants felt that being a Director of Nursing was not a favourable position for staff to fill as it encompassed many responsibilities. It was common practice within the organization that when the position was vacant, a staff nurse from the floor would be expected to fill the duties and responsibilities of the manager. It often left the nurse in an awkward position, as they did not have the proper training and were now in the position of managing their co-workers and friends.

When my manager left, like my senior manager, they asked me if I would be okay with looking after the other home cares until they figured out what they were going to do. Well, that is four years ago. And, they still have not figured out [Laughs] what they are going to do. (14: 127-131)

The various, unfilled management positions throughout the health region led to a void within the organization. This void often contributed to nurses feeling weighed by additional work pressure, as well as feeling isolated and alone within their workplace. As one staff described:

I do not know. I actually do not know my manager. I do not know if I am just like misinformed of what is going on. And I have heard it from like a couple doctors as well as that we just need a stronger resource for a lot of our clientele like our chronic 'detoxers.' (2: 637-642)

Consequently, the lack of support from management had an impact on client care, for nurses did not have the proper resources, knowledge, and education to keep current with their practice and to deliver relevant care to their clients.

Similar to home care, staff from other departments also spoke about how the lack of staff and management created challenges in fulfilling their work duties and responsibilities to client care. Participants described:

On weekends, on my days off and week-ends, they actually bring someone in as a nurse. They are assigned for eight hours to be on long term care. But they do not do any supervisory. (16: 514-519)

That can be applied to Public Health in general is that we have such small numbers of nurses that, as soon as you miss one or two nurses, things start getting dropped. Because you just do not have the capacity to continue to fulfil your duty. (20: 570-573)

Absenteeism in management and frontline staffing was challenging for the nurses to deal with, especially within a small organization, where the additional duties from vacant positions placed an extra burden on staff that already felt taxed within their current scope of practice. Generally, the impact of absentees can be more widespread in a smaller organization, as compared to a larger organization where a lack of management can often be easily absorbed within the system.

With a palpable lack of management overseeing nurses' roles and duties, staff did not feel like they had stability within the workplace. Many of the nurses within their various work departments did not know who was in charge. Additionally, on some units, junior nurses had never had an opportunity to work under management supervision. It became normal for nurses to not know who was in charge on a daily basis, which in some cases, extended over many years.

Furthermore, it created challenges in providing consistent client care as policies were not up-to-date, which influenced nurses' ability to provide safe and competent client care. The lack of management on a temporary to permanent basis started to create an environment where nurses became ambivalent or blasé about client care. Conversely, if they advocated for change, then they were viewed as being too 'passionate' about their work. This often contributed to the nurses feeling like they were on the outside or periphery of the workplace. In essence, health caregivers of the marginalized population started to become marginalized in caring for their clients' health needs, as they were expected to work with minimal resources. Through Critical Discourse Analysis, the nurse was starting to become the 'Other' through care and compassion of caring for the 'Other'. This process made it difficult for nurses to integrate back into the mainstream society, as they may experience and face rejection from their communities.

5.2 Public Portrayal of 'Native' Peoples

Within this research study, the predominant population was Aboriginal, more specifically First Nations people. The participants referred to their clientele as 'Native' people rather than as Aboriginal or First Nations people. However, during the interviews, the nurses that were of First Nations heritage did not refer to themselves as Natives; rather they identified themselves as being First Nations, or a First Nations person rather than a 'Native.' Additionally, First Nations patients that went to the health region for services presented themselves as being 'Native.' Through the views of the mainstream society, First Nations people presented themselves as being 'Native', rather than as a First Nations person. This

cultural distinction was important as it played a role in how nurses cared for their clientele and in how their viewpoints can affect their client's care and health outcomes. Within this section, *Public Portrayal of 'Native' People*, the data revealed how nurses and various stakeholders viewed their clientele and communities, as well as how these viewpoints can have an impact on their client's health and health outcomes.

5.2.1 By Nurses

Nursing Clinical Care

Within this segment, participants described how they viewed their patients and how their perception of their clients played a role within the care they provide to them. During the interviews, many participants spoke of the health issues that their clients and communities were struggling with on a daily basis. Some of these health issues included: alcohol consumption, drug and substance abuse, mental health and addictions, sexually transmitted diseases (STD), hepatitis C virus (HCV), diabetes, heart disease, and cancer. The participants described these health issues as communicable diseases or non-communicable diseases.

Throughout the communities, the participants' approach to nursing clinical care was not based on the etiology of the disease, but rather its focus became on the population that had the disease or illness. Through Critical Discourse Analysis, the data showed that being 'Native' was treated as an etiology for diseases or a justification of having advanced health conditions in comparison to non-Aboriginal populations. One nurse explains:

Native peoples have a 'god' given protection against hepatitis C than white people. They do not progress as severely as white people. Native peoples can be blasé about it. (3:27-29)

From this example, the participant expressed that being 'Native' constituted as a health factor of having a disease state. Culture as a determinant of health was not seen to help describe the reason for having an increased exposure to diseases, but rather as a determinant for having the disease state. Being 'Native' became a justification for having higher incidences of disease in First Nations people than non-Aboriginal communities. In another example within primary health care, one participant stated:

When you are doing your contact tracing, I always try to normalize it and say, "You know, it is a three month time frame. How many sexual partners? We'll need to contact them." This person actually had a significant amount. There was, I think six, six people they listed. And, inside, I was shocked, thinking, like, "Oh, my goodness, no wonder you are here." I always try to keep those internal emotions, my own personal biases and opinions to myself. I do not know, just trying to normalize it. I do not know if normalizing is necessarily a good thing. (20: 352-359)

In this example, the practitioner expressed that the number of sexual partners that her client had was abnormal to hear, but normal to the client. The nurses' initial reaction was to judge her client for having the disease. She also recognized that her knowledge of her patient's life style and choices had become part of her knowledge towards patient care. In the role of providing preventive care, the nurse was using her judgement towards her client in influencing how she interacted with her clients.

Similar to disease presentation within primary health care, other practitioners were also faced with how they perceive their patients and how their perceptions might impact their client care. For example, one mental health practitioner described:

It all depends on the individual. You are fighting and losing a battle by trying to give someone antidepressant if they are

drinking a significant amount of alcohol all the time. Again, with drugs, cocaine, it massively increases serotonin when you are taking it. But after that effect, it drops it significantly. That would diminish any effect from an antidepressant as well. Then, you would have to make a decision whether it is an alcohol and drugs problem or whether they are trying to mask a mental health issue. Of course, drugs and alcohol can both cause psychosis anyway in certain individuals. (11: 450-460)

From this example, the participant spoke about the complexity of diagnosis and assessment specifically in the areas of mental health issues and addictions. It was challenging for practitioners to treat a client without identifying the symptoms and understanding the root of the illness. Specifically, it was challenging for practitioners to evaluate treatment if not knowing if the treatment would be effective or relevant to the disease or illness state.

Community health nurses within remote nursing stations also spoke about how overwhelming it was to treat their patients' diseases and illnesses when there were so many diseases to treat at once. Furthermore, participants were extending their state of shock regarding their clients' poor state of health and disease as a representation of their population as a whole. In which case, the focus of treatment was not specific to the clients; rather it became heightened to treat the whole population for being 'ill.' The implications to care were that staff did not know what they should focus on in terms of priorities, as well as they had divided attention in terms of seeking educational resources and supports. In particular:

The things I put down as preventable stuff was obesity, drug and alcohol use, mental health issues, diabetes, heart disease, sexually transmitted disease, [and] addiction. Those are the main ones as well as cancer. Our system is fundamentally flawed. You can make small change. Ultimately, you are not going to make it.

You can make it better than it is; I gave up. [Emphasis added]
 I do not think there is any hope. (24: 288-294)

In the above scenario, it was difficult for the participant to focus his attention on a specific cause of action when his attention was divided into many competing areas of care. When dealing with daily presentations of high complex cases, nurses did not feel like they were accomplishing any goals. Perceptions of failure led the nurses to feeling hopeless and frustrated within their practice. It was difficult to distinguish if the nurse was frustrated with the 'host of diseases' or the 'host', as other participants have described. For example, one participant related her client's state of disease to the state of being 'Native'. As illustrated:

Native peoples are generous. But with alcohol, they are becoming more self-centered like white people. (3: 36-37)

In the above examples, the participants were frustrated with the high level of complexity that their clientele presented with on a daily basis. However, some participants were hopeful about how they could help contribute to better population health outcomes through their actions. As presented by the following examples:

If we go more the assisted living concept where people can still live in their individualized units, but have home care within that building to help people, and still remain as independent as you possibly can, I think you will see the quality of life better for all. As soon as somebody moves into a personal care home or a long term care, they deteriorate. I think we can keep people out in the community doing much better by providing more services to them out there than institutionalization. (14: 736-742)

I mean, living in communities that are across the North, there is 85% Aboriginal peoples. We want nurses who are culturally competent or are open minded to gain those skills and attitudes that will support Aboriginal peoples. (17: 176-178)

The last two participants valued caring for their clients with respect and dignity. Their nursing care was based in tertiary prevention in helping to prevent illness from becoming worse, as well as to utilize culturally-based skill sets and attitudes to help promote health within Aboriginal communities. However, the challenge was how do nurses with diverse perspectives work together, when their approaches to client care varied among themselves.

Skills, Values, and Judgement

Within daily practice, skills, values, and judgment can all play roles in how nurses communicate with their clientele during health care provision. Through the interviews, the participants spoke about the skill sets and values they thought were important within their work. Most of the participants offered that their skills and values were key elements in developing a relationship with their patients. However, during the data analysis, it was discovered that nurses' skills, values, and judgements of their patients could act, on one hand, as barriers to understanding their clients, or as strengths in providing compassionate and relevant care. The distinction between building healthy and unhealthy relationships was how the nurses viewed their patients and if their patients deserved to be treated with human dignity.

The following examples show the diversity in range of approaches to developing healthy to unhealthy relationships with their patients. For example, one nurse who was Aboriginal identified the following:

It totally depends on the nurse, on what their attitudes and beliefs are when they are providing their services. (6: 361-362)

I could give a needle anytime. If I am coming in there and not having the right attitude and the right frame of mind, that would not help the patients in the long run. (6: 387-389)

Her example illustrated that having the 'right' attitude and frame of mind can be helpful to her patients in meeting their health needs in a respectful and responsive way. In particular, respectful care can help develop a foundation where nurses are able to provide care that helps meet clients' culturally-based health needs.

However in the North, nurses needed to be careful of making cultural assumptions of 'Native' people as one. Within specific regions, each community had different cultural values that were influenced by various exposures to religion during the colonization of Aboriginal communities. It was challenging for nurses to develop and utilize this cultural knowledge into practice when they were not aware of this local community knowledge. The reasons for not having the local community knowledge varied from not knowing the local cultures to being new to the community. As illustrated:

In the North, it is quite different. We have different groups of folks. We have Dené, and then we have Cree. We have different groups of Cree. Sometimes folks, they find that it is really challenging to understand the culture of one First Nations group from another First Nations group. Some are traditional; and, some are focused upon Catholicism or being Anglican. The challenges are there, trying to understand what you are moving into. (22: 304-315)

Furthermore, it was challenging for the nurses to integrate cultural knowledge at a local level of care when they were new to the system and communities. Specifically, with being new to a community, nurses lacked the working knowledge of what was culturally accepted and what was the accepted standard of care. As stated:

I will recognize any cultural issues that they have. Everyone is a human being and should be treated with respect and dignity regardless of what background you come from. Obviously, I certainly believe that there is institutional racism in the Canada, Canadian system. (11: 201-204)

Within this example, the participant claimed that cultural awareness and recognition were important in providing culturally appropriate nursing care. However, it was not realistically based on systematic racism that was embedded in societal norms and values. The variation in societal values can contribute to creating an environment of divisions and separation for patient care based on their racial and cultural differences. For example, one participant contended that racism:

(...) could lead to tension. That is how I see my role in working as a nurse. I find that is how you have to be up here. You just have to be non-judgmental or else you would hate your job. Because there is a lot of crappy stuff that goes on. [Laughs] You just see it more when you are living in a small town and it is right in your face. (2: 299-304)

Within rural and remote Northern communities, social determinants of health played a significant role in influencing the health of their clientele and population as a whole. Cultural judgment posed a challenge for nurses to connect with the clients on a humanistic level. Through the interviews, some participants spoke about their values and judgements of their clients, specifically showing a lack of understanding of their clients' context of living and exposure to challenging life experiences. Within these examples, the participants placed blame on their clients for their way of life and poor health conditions. For example, one nurse stated:

If 'Native' people were not messed up maybe they would not do a lot of non-consensual sex/ 'rape' for trade or for life. It is complicated. They live life that they invite things to happen to them. (3: 45-48)

In further illustrating how systematic racism can trickle down to frontline nursing care, one nurse spoke about how 'Native' people were not genetically prone to change, and that the only way to prevent harm was to have a clean body such as an 'unborn child.' The nurse alluded to the idea that her patients' health could be impacted by living the life of a 'Native' person. Furthermore, she believed the way to implement change for 'Native' people were to start with a clean body. The nurse's values and judgement influenced how she approached her clients within her practice, where her beliefs supported her position of power over her clients. The nurse stated:

I am always taking it back to kind of those initial stages of if we can prevent harm to that 'unborn' child, maybe there is a chance of preventing harm later on in life. I am always doing that kind of upstream approach thinking. (20: 475-477)

In this example, the nurse's choice of language could show a distinction of being an 'unborn' child within a 'Native' family. There could be an understanding that the 'unborn Native' child will require health resources throughout his or her lifespan. Preventative care such as health promotion can be beneficial to Aboriginal persons.

5.2.2 By Stakeholders

Community Care

From the broader scope of community context, stakeholders also played a role in providing clinical care and health services to its clientele and population. Sampling of community stakeholders included, but was not exclusive to, administration personnel, leadership executives, and public policy makers. The following examples offered viewpoints from various perspectives and their influence on the treatment of community members. The first example illustrated that the current health care system was not customer-friendly, nor oriented to providing optimal client-centered care. For instance:

We do not always spend a lot of time on our first encounter with the clients because of the demands. There are some occurrences when nurses and staff will not always treat patients all that well because they are in a rush. Or, they are being presented with something frivolous and do not have time for that. In the States, for instance, where it is customer-based you want to treat your customer very good because that drives your income and funds your business. (10:439-451)

In the above example, the participant offered that the current structure of the health care system acted as a barrier in delivering client-centred health care services. Within this health care system, its functioning was not dependant on population health outcomes. Conversely, it was irrelevant if health care outcomes of a disadvantaged population were positive or negative. Specifically stated, the results of population health outcomes were not a factor in the delivery or planning of treatment services by stakeholders.

Another viewpoint pertaining to the delivery of community health services was that of health care policymakers. Health policies related to jurisdictional care can act as barriers in

providing equal access for clients. Specifically, services and access to services was dependent on a client's location and residence. For example:

If I was a policy maker, I would have one specific thing for the community to say. They should be, anybody needs to go out for a dental X-rays, CT scan, labs, or any kind of specialist appointment should be covered. The government should cover, if you are treaty or non treaty. (23: 415-419)

Being 'treaty' or 'non-treaty' created challenges in that not all services were accessible and available to community members. In particular, treatment of services was not based on their clients' needs, but rather on who was deemed appropriate to be treated. This form of policy contributed to creating geographies of exclusion.

The feeling of being socially shunned was voiced by community members. These feelings of social exclusion experienced by community members exposed an underlying layer of societal values and beliefs. The following example by a nurse demonstrated this from his client's perspective. As stated:

A lot of people from Native Canadian background perceive there to be racism within the health service. One of my clients was immensely upset this week, because she came to see me after being in one of the local shops. She had a big cart of stuff to pay for. There was this chap behind her with one thing. She turned around and said, "Would you like to go before me?" He told her to 'fuck off.' She said, "You have got no right to tell me that." Then, he called her an Indian squaw. I have had a number of different clients who spoke about (racism). (11: 183-197)

For community members, racism was a part of their everyday life experience, whether it was from accessing health care services or performing day to day routines such as grocery shopping. Systematic racism contributed to challenges felt by clients in accessing fair and

equitable health care services. From these stories, there was a connection between the client's experiences and social exclusion related to systematic racism and embedded within community living.

Programs

The delivery of programs within the North was dependent on funding from federal, regional, and provincial stakeholders. With the current nursing shortages and vacancies, it was difficult for managers to deliver their programs within budget. For example, overtime and replacements added an extra cost to program delivery, and when the cost was on a continuous basis, budget overextension became a normal state of affairs. This pressure was felt by nursing managers:

We were a problem because we were costing money. Because what I had to do is I had to bring in lots of casuals, right? Their stats are really low. But mine are just out of the water. Budgetary wise, it is bad. If it is a client of mine that, or somebody that I should be looking after off reserve, we will try our best to look after what we can. (14: 485-490)

Adhering to a budget capacity created challenges in providing health care services to a population that has poor health outcomes, which in turn, demanded greater attention in delivering preventive services. Specific to program delivery, health care professionals offered what they could in trying to operate their programs within their capacity. For example, one practitioner declared that primary prevention was important, but due to the high needs of his clients, preventive care was not enough. The following is an example of a patient presenting in a primary health clinic:

They are pregnant and did not come for contraceptives beforehand even though they were not planning to become pregnant. We try to be creative, if we see a young woman who's sexually active and we ask her if she wants to be pregnant and they say "no" even if they are there for an infected toenail we have a lower threshold of asking those questions and managing multiple medical complaints in one visit. It is a drop in the bucket compared to what the need actually is. (10: 440-450)

In this example, the practitioner described his frustration that, despite the delivery of programs and health care services, his actions fell short of making a difference in population health outcomes for his clients.

In delivering Northern health services, another practitioner claimed that the population that they serve has many social issues that can impact their health. The nurses did not feel like the care they provided would be able to have much impact on their client's health. However, some nurses were taking small steps in providing preventative measures that they could implement, such as sexual health preventative care. For example:

The Probations office expressed the interest, because they said, "You know, a lot of the clientele that are charged or on probation, it is because they do have some addictions and health issues", whether it is drugs, alcohol, prostituting or whatever the case may be. By offering them condoms, at least, we are using a harm reduction approach in that regard that they are not spreading disease, that they are preventing pregnancies. That is something that Probations advocated for, because they saw it as a good thing that we can assist those people. (20: 630-636)

Through Critical Discourse Analysis of the data, it became apparent that there was a clear distinction between the health care professionals and the clients that they cared for. In the above example, the nurse viewed her clients as 'those people'. Her lack of relatability to

her patients almost provided her protection against being like ‘those people’, or having to treat ‘those people’ as equals. Nevertheless, this approach to care was not shared by all practitioners. One nurse argued that it was important to incorporate cultural understanding within delivery of programs and services. For example:

It is important to have an idea of each culture and what they believe in, and what their common practices are. The more you are able to learn some words in Cree or Dené or any other languages that are spoken here, the easier it is to talk with your clients and work with them. (7: 339-345)

Another participant spoke about how the delivery of programs and services offered should be directed to address issues related to health inequities. In the following example, the participant spoke about how education and literacy within maternal health services could help to improve population health outcomes through primary preventive measures. For example:

Through the Northern community, healthy community partnership, we've got a program going called Babies Books and Bonding. Addressing literacy as well as sort of parent bonding with infants. Infant mortality is an area. One of our strategies to address infant mortality has been through a prenatal nutrition program. Using sort of a kitchen table approach, cooking classes that get not only prenatal women, but also, their support, their extended family members, even their kids together. (17: 336-342)

In this example, the participant included families and communities in educative strategies for her clients, as she wanted her clients to feel supported. As evident, within these various examples, public portrayal of clients by nurses and stakeholders played a significant role in the delivery of health services for clients. For instance, nurses’ attitudes of how they viewed their clientele and population impacted how they approached care in that the value they placed on

client care was noted to be influenced by the value they place on their interactions with clients, that is if they were worthy or not of care.

5.3 'Native' Communities

The perception of how nurses viewed their population of communities played a significant role in how they cared for their communities during care. Within this section of *Public Portrayal of: 'Native' Communities*, there were two sub-themes including: *Interjections*, and *Formations*. Specifically, interjections referred to how nurses viewed their population of communities; formations addressed the process of how the nurses created their impression about their communities. Both sub-themes brought forward uncensored expressions of how the participants felt about their communities, and how their community's health issues were related to the notion that their population was 'Native'.

5.3.1 By Nurses

Interjections

Interjections brought insight into how nurses viewed their population and how they perceived their communities' health issues to be related to the state or condition of being 'Native.' From this section, some of the examples offered that being 'Native' was almost like a condition or a state of poor health affairs. For example, one nurse argued that:

Kids are ruined before they are born. Drinking during pregnancy and addiction to morphine. (3: 63-64)

Similar to the quote about the 'unborn child', the nurse offered that the poor state of health affairs for these children related to them being 'Native.' In general, the participants within

this study expressed that they did not have hope for the children, as they were part of the 'Native' community. In particular, the living conditions that the children were exposed to were sub-par to the normal expectations within acceptable limits of societal living. One participant stated:

We have a very large youth population and that youth population is high risk taking in terms of their behaviour. We have very high incidents of sexually transmitted disease as well as high rates of teen pregnancy. In some case, there is even pre-teen pregnancy. That is another area where I think nursing could focus on is. Meeting the needs of kids and sort of bringing that message to them around safer practices. (22: 173-178)

The expression of lack of hope for living a normal, healthy life was extended to other areas of health including public health, sexual health, and infectious disease. The impression that the nurses had from working with their clienteles was that high sexually transmitted disease rates were part of the condition of being a 'Native' person or being from a 'Native' community. The focus of care within treatment was centred around the nurses' roles and duties of caring for the client, rather than focusing on treating the client or on healthy living.

For example as illustrated by the nurse:

Through the Public Health, there are communicable diseases that are notifiable. Automatically, like hepatitis C, HIV, any of that kind, salmonella, Giardia, Scigala, any enterics, there is a variety, a whole list, and any sexually transmitted infections (STIs). We get reports from the provincial lab. A lot of times, we get the reports before the ordering physician does. It comes to their office first. Their names are always included on the lab

reports when we get that. Our job here is just to ensure that those reportable diseases are followed through. (13: 222-229)

Within this example, the client and community of care became irrelevant to care, in that the nurses' roles and duties were more pressing than meeting the client's health needs. During their work, nurses had formed impressions of their clients that informed how they should care for their clients. For example, one nurse described that she goes beyond her duty of care because her clients lack the family support or social structural supports that are common to 'Other' societies. As described:

Yes, I will pick up pills for people, and monitor them, and make sure they are getting their meds, because they do not have family members. They are living on their own. There is no other family. There is no social service agency that will do that kind of thing. (15: 175-178)

During the interviews, the nurses were expressive about how they viewed their clientele. Mostly, it became apparent that the nurses viewed themselves as being different from their clientele. In essence, participants described that it is part of their roles to save their clients from the conditions of being 'Native'. For example, one participant stated:

I am always confused as to what the proper term is nowadays, but foetal alcohol, neural tube defects, alcohol (...) or not alcohol, drug consumption, like anyway that we can prevent harm to the baby I think is something that is preventable. We have been trying to revamp our prenatal program by doing visits with them during their pregnancy as opposed to just sending them an information package. (20: 464-469)

During their client interactions, the nurses felt like they were doing their best, whether there was evidence to support their projection or not. However, not all nurses shared that

same sentiment. Some nurses felt that no matter what they did, their clients would still suffer; in essence, suffering was inevitable. As described:

I had a young fellow who was suicidal. The hospital did not want to take him in. They said, "Well, he is not acutely suicidal." I could not find a place for him to stay. Turns out, he had to go to the hospital. I called a plane to come get him. I was waiting at the airstrip and the plane flew over running a circle, did another circle, and then flew away. I am like, "What is going on?" And, I looked at the lights for the runway, it did not come on. I am like, "Oh, shit, now, what do I do?" The plane left. [Laughs] I called them. And they said, "Oh, we cannot turn the lights on. Sorry, we cannot land the plane." I am like, "What do I do with this guy?" I took him to my house, and was listening for him to try to leave my house. (24: 212-233)

For this participant, the suffering of his client became his own suffering. Nurses that were sympathetic to their client's suffering were starting to endure their own sense of suffering. The nurse felt like what he did was neither effective, nor efficient for his client to be healthy and safe. In experiencing his client's distress, the nurse was starting to experience what it was like to be the 'Other.' He was starting to feel as isolated as his clients did within care. Essentially, the nurse was distinguishing himself from his peers through the choices he made for his clients.

Formations

During the interviews, participants also described the process of how they created their impression about working with their community of interest. During their practice, nurses formed impressions of their clienteles, which they used as justifications and rationales for their clients' poor health status and outcomes. Thus said, it was important for nurses to

maintain their distinction from being like 'Native' people because they did not want to become them, or what 'Natives' represented to mainstream society. For example, one nurse described:

Violence is increasing in the media. For example: universal fighting, ring fighting, and video games. People are acting out what they see and do not know the consequences. We are going back in society. We are becoming more violent in society: White people, Native peoples, and our whole community. (3: 66-69)

In this example, the participant had lived in the community for over thirty years and felt that 'White' people and 'Native' people were starting to assimilate together in terms of cultural images and identity. Participants were concerned about preserving their own identities.

Another participant offered his generalization that 'Native' people were not, in general, successful and that they represented a 'lower class' within society. For example, he stated:

There are very few people from a Native Canadian background who go to the top. I do not know any native Canadian doctors here. And there are very few native Canadian nurses. That is institutional racism. (11: 241-243)

But, again, the 99% of the people you will see on drugs or alcohol, in a bad state, are Native Canadians. (11: 282-283)

Other participants described that they associated 'Native' people with being dysfunctional within their communities. The participants created their own 'truth' of how they saw 'Native' people to be within society. For the participants, being 'Native' was associated with being dysfunctional and it was important for them to contain the dysfunction among the 'Native' communities.

A lot of the communities are high in dysfunction. They are witnessing - for lack of better words - bad behaviour. There is a lot of trauma that occurs, a lot of domestic violence that occurs. What they are seeing on a consistent and regular base is a repeat of people coming in with black eyes, broken bones, being abused by a spouse or parent. There are high incidents of sexual abuse that goes on in the communities. Nurses are on the frontline (...) we place an expectation on community nursing and Public Health nursing. They are stuck with this barrage of dysfunction. (22: 218-226)

It became evident from the data analysis that participants wanted to maintain their independence from the 'Native' communities because they did not want to be associated with the barrage of social issues that 'Native' people experience on a daily basis. For example, one participant explained:

There was a fair rate of abuse and sexual abuse. These things are passed down from generation to generation. Just to take into consideration maybe that although this happened several years ago, we are still seeing the effects of that. It does not have to be in somebody's life who attended a residential school. We just always have to be mindful of any sexual abuse situations and any disclosures that may come as a result of talking about sexual health. (4: 289-295)

Through a postcolonial episteme, this participant was trying to understand the issues of sexual abuse within the community by understanding the social, historical, and political context that has impacted the health of her clients. Within this context, the impact of residential schools can have a multi-generational impact on their clients and their clients' health. However, without this understanding of historical context, it was difficult for nurses to understand how to implement preventative care in meeting their clients' health needs.

Although participants had empathy for their clients and what they had endured, they were often relieved that they were not 'Native.' In particular, nurses that were non-Aboriginal felt relieved to be part of the 'normal' society. As illustrated:

There is just so much devastation with past history of residential schooling. This had the effect on the alcohol and drug abuse, and, sexual abuse with many of the broken families. I used to think how fortunate I am that I was raised in a normal family or whatever you want to classify as normal. [Laughs] (20: 481-487)

As frontline care providers, nurses also felt like they were working with their clients on the fringe of society, almost joining them in the marginalized edges of society. Participants explained that, despite their care and best efforts to prevent illness and diseases, their interventions would be in vain.

I gave up. I do not think there is really any hope. You can make small changes to affect people's lives in a positive way. Ultimately, people need to do that for themselves. But, as a whole, the numbers are just going to get worse. (24: 294-297)

From the nurses' viewpoint, providing Northern health services was proving to be irrelevant and ineffective as the impact of the history of colonization on their community's psyche was too large of a task to address. For instance, the impact of colonization had and has long lasting impact to their clients' health, and the damages were being seen on a large population health scale. As illustrated by the following examples:

It is not rocket science. Everybody wants a shelter over their head. They want to be loved. They want food in their tummy. Nobody wants to be a drunk on the street. Nobody wants to be hungry every day. Nobody really wants to be a drug addict, right? It is just your whole life of things pile up. (14: 316-322)

You beat people down for generations. Then, you institute religion which, there is a lot of lies and misuse of power within the religious community. These people are essentially taken advantage of. There are not a lot of choices. It is hard to go back and live like they did 50 years ago. (24: 310-315)

Within the above examples, the participants offered that there is value in human life of the marginalized. However, the integrity of human life was stained with the impact of colonization on a society. The damages of colonization on daily life were detrimental to the people and communities carrying that affliction. Additionally, it was difficult for outsiders entering the community to help create change when the integrity of community living at large was affected by colonization and embedded in the community's living memory.

5.3.2 By Stakeholders

Care Directives

During the interviews, participants expressed that their care directives were influenced by stakeholder decisions such as the Executive Leadership team and the Ministry of Health in Saskatchewan. There were two departments that seemed to be of significance to the Ministry of Health in the delivery of Northern health services, such as mental health and addiction services, and home care services. For example, one key informant offered that when he made decisions for his programs, they were based on the external input of the Executive Directors.

As illustrated:

In the province, we have what we refer to as the regional Executives Directors of mental health and addiction services, who meet regularly and we discuss ways to improve the direction of our services. (22: 51-53)

However, participants expressed that it can be challenging for them when decisions are made at an executive level because it often does not translate well into practice. One participant described how she felt being placed in the middle between her clients and the Ministry of Health:

When I am trying to deal with the Ministry, for instance, when I am trying to implement new initiatives for programs and stuff, they cannot understand why I cannot give them their full attention. The reason I cannot give them full attention is because: I have done all the scheduling, get the vehicle fixed, go out and be a nurse, and bathe my clients. I had a disgruntled nurse. I am listening to my nurse, because she is upset. I have somebody that is dying. I am hauling equipment out to get them set up. This is what my day consists of. (14: 587-594)

Within the above example, the participant explained that her priority was not with the Ministry of Health, but in caring for her clients within the community. Her story showed that the Ministry did not necessarily understand what her work day consisted of, nor did frontline events have an impact on ministerial decisions. Another manager spoke about how her and her frontline staff had expectations from the Ministry of Health that were not realistic. She implied that the Ministry of Health was removed from the everyday crisis that happened in the North and was not aware of the competing priorities that nurses had to meet with limited resources. Without clear directions, it was difficult for managers to direct their staff to meet priorities when lack of leadership was palpable throughout the organization. Upon reflection:

I can look back and say, "Yikes." If you think of all the priorities including: patient first, the patient safety, medication reconciliation, Falls prevention, infection control, and suicide prevention. There are many things coming at you at once that

you are expected to know. Who is running the show? (25: 401-407)

The above participant described feeling overwhelmed with all her priorities. This contributed to nurses feeling like they were alone and isolated. They were left with a sense of impending doom, which was overwhelming to both nurses and managers. Within the following examples, the participants described their need to advocate for resources within their war-like atmosphere. As further described:

We keep mouthing off how we want to get out of these silos and operate on an integrated process. But, yet, we keep our work plans to ourselves. It is sad. It did not work during the Second World War. [Emphasis added] It is not going to work in 2011. (22: 533-535)

We are forgotten about. It seems like we are not cared about. Even if we do continue to raise our voice about the issues that exist here, someone pretends they care, but actions will actually show that they do not care. We've been fighting for a vehicle that is reliable for like since I got here. This is a legal issue, and an ethical issue. Somebody needs to be fighting for these people for this community. It cannot just be us. (24: 263-273)

Overall, participants felt that it was difficult to create change when they felt abandoned by the Ministry of Health. Furthermore, participants expressed that the Ministry's priorities were not often in harmony with the many priorities that nurses were facing in practice. In essence, the nurse at the frontline level of care felt the disregard for 'Native' people by the Ministry of Health. Nurses felt like their actions for their clients were in vain, for they perceived they were losing the 'war.'

Jurisdictional-related Care

Another element that played a significant role in the delivery of Northern health services was surrounded by the ambivalence as to which governmental sector was responsible for funding and care provisions. The nurses working in the community described the presence of a two-tier system that consisted of either being 'on' or 'off' reserve. Services that were 'on' reserve were covered by the First Nations Band, whereas services that were 'off' reserve fell under provincial delegation. This structure was illustrated by the following examples:

We are set up here with our health system. There is the band health and then there is us. (12: 163-164)

There are a lot of issues that the family or community is dealing with. Immunization is such a low on the priority list to, you know come to the clinic for that. They do not have a car. It is trying to get there. That is definitely a challenge. Up in the North, we have two systems. We have the 'on' reserve and 'off' reserve. (13: 154-160)

The implications for frontline nurses were that they did not know how to cross the jurisdictional barriers, or how to navigate around the boundaries that were in place. One participant explained:

I have worked on both sides of the fence for the Indian Band, which is federal and the region, which is provincial. Sometimes those jurisdictional boundaries are a headache. People get lost in the system, they fall through the cracks. [Emphasis added] People get lost in the boundaries of government (...) people are suffering because of it. (20: 666-680)

The nurses were frustrated with the divisions and lack of consistency of who provides services and how funding was decided amongst the various authorities. For example:

Home care services are increasing with human resources and the Band. If Treaty and 'on' reserve, the Band looks after them. If Treaty and 'off' reserve, human resources covers. This is discrimination. The band should look after all Treaty. They (the Band) are discriminating against their own people that choose to live off the reserve. If treaty and live 'off' reserve, they have to pay for their own taxi. If treaty, you are treaty. (3: 115-123)

One manager described that service was not dependent on clients' or population health needs, but rather on whom the financial funder was and what they were willing to fund. The challenge of this system was that it created inequities in services, and demonstrated a lack of transparency of how the decisions for funding were made. The limitations to the system included:

First Nations Health Authorities receive separate funding. A lot of their clients come off reserve to receive services. It would be easier to share resources (...) there is an imbalance in what is available 'on' reserve and 'off' reserve. Sometimes, there is more 'on' reserve. Sometimes, there is more 'off' reserve. It depends on the funder and what they will fund. (17: 408-425)

The inconsistency in funding was a challenge for nurses in delivering Northern health services. In particular, nurses did not understand how decisions were made or how long the funding will last. This created a feeling that programs and services were collapsible and unstable. Furthermore, other nurses felt that the division of programs by the various funding sources were contributing to various acts of 'racism.'

In Canada, people are pushed off into their own areas. If you keep pushing people off into their own areas and do not let them become a multi-cultural society, it is only going to lead to different groups having strong feelings against each other. This is a new experience for me, these different areas of different people. Watching this society here, which is pushed off into its

own little areas is quite an interesting experience. I can see why it breeds racism or distrust, if you are not allowed to mix. (11: 220-229)

Critically speaking, the visibility of 'racism' contributed to lessening the likelihood of 'Native' people's ability to survive their hardships. The structural inequities of the health care system were too great to overcome. This contributed to nurses' challenges in navigating through the system as the rules were unclear and the outcomes for their clients' health were devastating.

Additionally, the systems' inequity within health care led to moral discord for the nurses in trying to understand how some of their clients received health services, and how others did not based on their valued position in society. The nurses were facing moral distress in enforcing ministerial decisions that had detrimental impacts to Aboriginal peoples. In coping with their stress, nurses created a separation from their work in an effort to escape the system. The challenge was it was difficult for the nurses to maintain this separation as they were the central resources of the system. In this sense, they were not able to address their distress, as they were an extension of the government. Within their practice, nurses were utilized as operational tools in maintaining a segregated society.

5.4 Colonizing Nursing Practice

Through Critical Discourse Analysis, it was becoming evident that nurses within the North were in a difficult position of providing Northern health services with limited, and possibly, restricted resources. The community's health needs were not in accord with the needs of the government's mandate. As so, nurses were working within an environment where their mandates were unknown and non-committal. It was also unclear as to where the nurses'

loyalty lay, whether it was to the government or to the community, and it would be difficult to be to both. This section, *Colonizing Nursing Practice*, presents an uncomfortable position, and yet one which where nurses are expected to assume, as agents of the state, in suppressing population health of Aboriginal peoples. The first segment included Public Health Surveillance.

5.4.1 Public Health Surveillance

From the data analysis, the role of public health surveillance was one of the sub-themes emerging from *Colonizing Nursing Practice* in Northern communities. *Public Health Surveillance* referred to the data collection and the gathering of information to guide directions and actions towards health protection.

Mental Health and Addictions

Under public health surveillance, many of the participants spoke about health issues that were categorized within mental health and addictions issues. Some of the staff had experience in mental health and addictions; however, even senior staff were exposed to social issues that they found beyond their comfort level in practice. For example:

We deal with all forms of mental illness within the office. We also deal with many issues which are not classified as a mental illness and are more a social or emotional problems. There is certainly a big role for us to do that here. For example, marriage breakups, we would support someone if they were finding it difficult after the end of a relationship. People who are being bullied, we will support. And, people who have lost their job, we would offer that kind of emotional support. (11: 80-86)

The above participant spoke about the need for community health services to be all encompassing to address wider-scope social and family issues. Another participant spoke about the impact of social issues as not an isolated issue to clients, but extending to family members and the community as a whole. As illustrated:

It is the stragglers in some of our homes that cause our clients the problems. Well, the family member that has been gone and then comes back and is drinking and smoking, into the pot into the drugs quite bad, is bringing that behaviour into the home, you know, things have been balanced, family has been doing good. Now, we are in an upheaval again. (14: 283-289)

From her experience, the above participant talked about how there was a cycle in working with clients and families with issues of substance abuse and alcoholism. The participant also spoke about how the damages of substance abuse and alcoholism can have a detrimental impact to one's health:

I have seen a lot. [Emphasis added] In their younger days, they were heavy drinkers, heavy smokers. And, of course, then, right as time goes, they start to get the health issues. They may have had quit, but we are still dealing with the after-effects of that, because of their bad habits. (14: 269-272)

Breaking bad habits was difficult to do as it did not address the underlying reasons or etiology for the stated diseases and illnesses at hand. The nurses narrowed the etiology of their clients' health illnesses and diseases to their clients' poor health choices. For these nurses, the focus of illness originated at an individual level of health. Without knowing how to break bad habits, nurses felt unprepared and ineffective to create change for their client's health status. In needing a bigger picture of health inequities, some nurses spoke about the flaws of the system at a global health level of governance. For example:

It is all flawed. And, if you continue to sell people junk and poison, they are going to use it. You can educate some of them to not use it. But, at least half of your population is going to use and abuse. (24: 306-309)

Once you give people all those modern luxuries, it is an addiction. I believe it is purposefully done. The purpose of economics is to entrap these people, feed them a whole bunch of cheap garbage, make them sick and then sell them a whole bunch of drugs to help cure their diseases. (24: 315-319)

Some of the nurses working in the communities were very critical to the role that the government had and continued to have in creating the social and health issues that their clients were afflicted with. During the interviews, nurses expressed a range of emotions from anger to frustration to compassion. The nurses were aware that the extent of the substance abuse and addictions within their communities would not be an easy task to address. As a result, their clients were suffering. As described:

Drugs and alcohol. Cocaine. They keep sniffing it. Cocaine is a huge problem within the local community. And it is a very expensive drug as well. So, people have to resort to other means to afford it. And alcohol as well is a significant problem here. If you go down to the main walk, there'd be people who are suffering from effects of drugs or alcohol any time of the day. (11: 262-273)

From the interviews, the nurses spoke about an underlying darkness that clouded the community with mental health and addictions issues. These issues not only affected their clients, but also their families and vice versa. The nurses were aware that the complex health issues of Aboriginal peoples were connected to the social and political consequences of governmental decisions. However, the nurses were uncertain as to what their roles or influences of power were in addressing these issues.

Communicable Diseases

Another category under Public Health Surveillance was communicable diseases within the community. The main communicable diseases that were identified by the participants included sexually transmitted infections (STIs), HIV, and TB. Some of the participants described treating STIs as if it were routine, and having no consequence to them as health care workers. One public health nurse approached STIs as being easily preventable with educational programming. For example:

The most common preventable health issue is Sexually Transmitted Infections. It would be the main one. We have very high STIs rates in the North. I think it is easily preventable. It is just a matter of providing the education out there. And, follow up on a timely manner to catch or treat those that are infected and their contacts. (13: 305-310)

However, other nurses were quite challenged with trying to understand the reason for the high rates of STIs within their communities, specifically amongst the younger population. For instance:

With the target group that I am working with they have the highest rates of Chlamydia and Gonorrhoea. Out of all the health regions, we are in third place. Probably related to the socio-economic status. The sexually transmitted infection (STIs) rates are the highest rates for ages 15 to 19 years-old. The females over-represent those numbers. Most likely because they have more contact with the medical system than do boys. And, many STIs are asymptomatic. (4: 160-194)

In the above example, the participant addressed a challenge that many nurses experienced within their practice. This challenge was that it was difficult for nurses to prevent STIs and trace sexual contacts without having access to the client or their information for

further testing, particularly for vulnerable populations like children. In addition, it was challenging for nurses due to the fact it was a taboo subject of pre-teens and teens having sex. Children were less likely to seek help without the knowledge that they have an issue. It also became normalized for children to have untreated sexual transmitted diseases, often common among their population cohort.

Another challenge that nurses faced in working with communicable diseases was that the rate of diseases were not only at a high rate, but also increasing at a fast rate. It was challenging for frontline care providers to keep up with the current volume of communicable diseases. It was an added challenge for nurses to treat the number of diseases when their case load was always growing. In particular, this challenge pertained to treating and containing the number of HIV cases:

We have an increasing HIV population. This is another huge concern that I have. It is not so much amongst kids, but it is growing in leaps and bounds amongst the young adult population. (22: 180-184)

Treating HIV clients created vulnerability not only for the clients, but also for the health care practitioners. Working with children, youth, and the young adult population can be difficult for nurses to know that this sub-population has communicable diseases that can be easily spread among their cohorts. Having communicable diseases at a young age can increase the risk of populations having the diseases especially for incurable diseases through a lifetime of contact.

In working with communicable diseases, nurses also spoke about the challenges of treating and containing cases like HIV when their clients also had substance abuse or drug

dependency issues. Substance abuse added an element of complexity to treat and manage symptoms stemming from other illnesses. For example:

Not so much causing complications with the methadone, but it cause the sort of psychological aspect of being HIV positive. This causes difficulty with managing a methadone maintenance program. (22: 192-194)

Caring for clients with communicable diseases was challenging because the nurses had to be aware of the psychological impact that these diseases can have on their clients' sense of self. Within this population, nurses described that their clients tended to have more than one disease, and that the state of multiple diseases can be too advanced to treat. Nurses also offered that their high risk population was generally exposed to many communicable diseases that could have otherwise been prevented. For example, one participant explained that clients were vulnerable because they were at high risk of being exposed to other diseases. Clients were at an additional disadvantage of not receiving effective treatment, as their care was too complex for nurses to treat. As described:

It involves everybody. It involves clients having access to HIV care and high risk people having access to testing (...) our clients have complex needs. It is something that we have not seen here before. [Emphasis added] We are not used to dealing with it. Staff do not feel like they are informed enough to treat their clients. (18: 97-106)

In summary, nurses felt like they were not well prepared to treat their clients as their clients' disease states were above their area of knowledge and the required scope of treatment was beyond their range of expertise.

Tuberculosis (TB) was another communicable disease that nurses treated their clients and families for within their practice. The rate of TB in Northern Saskatchewan was high. Specifically, the volume of treatment was challenging for nurses and the public health unit to manage. In particular, nurses felt like treating TB was a losing cause. The nurses felt that the rates of TB would not change unless the social infrastructure changed. For instance, housing and poverty were social determinants of health that nurses recognized as having a significant impact on the growing rate of TB. As described:

The housing situation is overcrowded. Somebody is sick with some kind of respiratory illness. A full house, right. [Emphasis added] If the housing needs are met, then that will cut down the number of people who will require follow up treatment. (23: 207-215)

Housing is terrible, and look at our TB rates in Northern Saskatchewan. The whole number of diagnosed cases in Saskatchewan was 81 in one year. But, 59 of those cases were in the Northern health regions. That does not leave too many throughout the rest of the province. [Laughs] (25: 256-262)

Frontline nursing staff and managers recognized that it was difficult to decrease the number of communicable diseases, specifically with the high risk population. Participants felt like they could not help their clients, as they could not change the social infrastructure related to many of their clients' disease states.

Non-communicable Diseases

Similar to communicable diseases, nurses were also overwhelmed with the high rate of non-communicable diseases that their communities faced, particularly with Diabetes Mellitus Types

I and II. In general, diabetes was identified as a prevalent health care concern facing the community. For example:

The biggest health problem in our community is diabetes. Diabetes type I and type II diabetes are the biggest preventable health problem in our community. (23: 156-162)

The impact of diabetes on the community was stressful and had many implications not only to the individual, but, also to their family and communities. For the nurses, the prevalence of diabetes was like a window into the community of its social health issues. In particular, the high rate of diabetes was related to the social determinants of health such as the issues of poor socio-economic status. Other factors included lack of access to healthy, safe, and traditional food. Having a diabetic epidemic within the community was alarming for the nurses within the community. The nurses were becoming witnesses to the decline of the population health of their community. As explained:

Diabetes brings a lot of stress to our patients' life. It is just out of control. That is specifically related to the socio-economic problem. Most of the people are extremely overweight. They do not have good accessibility to good food, even if they want good food. The only thing we encourage them is to go back to the traditional diet. We have a lot of Type II diabetic cases in our communities. It is becoming younger and younger, between ages 35 and up. (23: 172-183)

Some of the nurses had experiences of working with other Northern communities within their region. This gave the nurses a wide-scope view of working in the North. For one participant, she saw a relationship between health and one's natural environment. Connection with traditional food and activities was a way for community members to feel like they were linked with their environment. With being disconnected to their traditions, it was difficult for

clients to feel connected as part of their community. One participant claimed that the symptoms of diabetes and illnesses can be related to the separation that their clients experienced from their traditional knowledge and practices. For example:

In my experience in Nunavut, for obesity and diabetes, everybody went out for the seal hunt. They ate a lot more traditional food than here. They are trying to get back to more traditional food. But, here we have 2500 people on the 'far' reserve. They do not have access to traditional food. The size of our community can be a problem for staying connected to traditional activity. (10: 337-391)

Being on the reserve, specifically the 'far' reserve made it difficult for community members to communicate the needs of the people. Similarly, it was difficult for nurses to be aware of the activities of the community without being a part of the community. One of the key parts of community health assessments was to be aware of the environmental impact of industries on health. Environmental health assessments were identified as an integral element of community health assessments. As stated:

A big part of our job is reviewing environmental impact assessments by industry and ensuring that they have included an assessment of health impacts of the industrial development. (17: 295-297)

Another health issue that was widespread within the community was Chronic Obstructive Pulmonary Disease (COPD). Community health assessments were important to nurses, especially for home care nurses who were exposed to many of the health issues within their client's homes:

We have tremendously lots of foot care issues among our clients. Yes, it is related to diabetes. And just chronic illness, aging. Poor health from an early age. I do not see TB in my

practice, but it is certainly out there. Just chronic disease management, COPD, smoking issues, emphysema. COPD would be a huge disease in the practice. And, the smoking issues are not helping. We have people with mobility problems, arthritis, and severe arthritis. (15: 148-158)

Within the community, home care nurses seemed to be the centre of care for treating community health issues. In particular, home care nurses were exposed to the wide-scope health issues that their clients were experiencing on a daily basis. For example, many of their clients had:

COPD, diabetes, heart, and the 'whole gamut'. Lots of them, because they are living in inadequate housing, and, their family members are smoking and there is the drinking. It is the whole cycle that still continues on. Sometimes, you can sever that. But we've only had a few success rates with that, with some families where we've worked with the whole family to help them change their lifestyle. (14: 274-279)

Non-communicable diseases including diabetes, COPD, heart disease, and arthritis were examples of common health ailments amongst the Northern communities. Conducting community health assessments was an important step in helping nurses to better understand the connection that their clients had with their environment. Community health assessments provided nurses with local contextual knowledge of how to address health issues from a community health perspective. This approach helped create community-based solutions that facilitated the implementation of health promotion strategies for their clients and communities.

5.4.2 Gate Keeping

Patient Accessibility

Along within *Colonizing Nursing Practice* was the sub-theme of *Gate Keeping*. Specifically, patient accessibility and community accessibility were elements of gate keeping within Northern nursing practice. Nurses working within rural communities often found themselves acting as gatekeepers to health services for their clients and communities. For example, nurses found it difficult to deliver health services to their patients on the reserves and ‘far’ reserves, as the geographical distance was too vast to cover. Specifically, it was challenging for nurses to know who needed service without direct contact with their clients. The lack of access to their clients created challenges for nurses in being able to locate and connect with their clients. As well, the vast service area challenged their ability to provide their clients with timely service.

For instance:

We are 2500 on ‘far’ reserve and then another 2500 or so in town, we are not connected. The band might have a bit of a different feeling. But, from people I see and just what I even hear socially, there is a lot of older women who do not really feel like included. Nobody knows how they are doing and what is going on with them. Nobody knows. (9: 391-397)

Access to their clients and the ability to provide safe care was also affected by the nurses’ access to their clients’ health records. Without having timely access to patient records, it was challenging for nurses to provide care that met the needs of their clients. For example, one nurse spoke about the challenges of providing care to her clients without immunization records. As described:

I often am missing like maybe 10% to 15% that have no immunization records. I am phoning every health region in the

province. Every different community to try to find immunization records for families that might have moved here for whatever reason from somewhere else. (12: 309-312)

Another element of Northern nursing practice was that it was difficult for nurses to locate their clients. Most of their clients did not have a permanent residence, making it difficult to provide follow up care. Specifically, trying to contact their clients on a regular basis challenged the delivery of essential health services including preventive health care. Furthermore, nurses had the impression that Northern communities were laden with more health issues as compared to other parts of the province. For example:

When you think of the priorities for some of the families down in more of the southern communities; housing and food security isn't such an issue. Unfortunately, in the North, you see a little bit more of that. You see some crowding. They do not have money to get a cab to come there or they do not have anyone to watch the kids, or just the lack of support for the kids. (13: 189-197)

Additionally, the negative imagery of the community had a detrimental impact in trying to recruit nurses, particularly new nurses, to work in the communities, as well as nurses from other departments to work in home care. For instance:

I do not know why. [Emphasis added] I try to recruit over from acute care and say, "Why do not you come and work with us in home care?" I do not know if that is because they view the community as having some issues. I do not know. (15: 228-230)

With the shortage of nursing staff in home care, it was difficult for nurses to provide adequate nursing care and needed health services to the community. In this light, many of the participants expected that clients should come to their clinic or hospital for services. However, other participants spoke about the need for nurses to provide health care services within the

client's home. Given the difference of opinions, nursing care needed to embrace flexible ways of reaching out to their clients. For what usually worked in the cities or in the southern parts of the province, did not necessarily work in the North. As explained:

That is one area that I think really needs to be sort of improved upon is that whole mindset around getting into the homes of folks and bringing the services to them, as opposed, to kind of sitting here and expecting them to come to us. It won't work. (22: 152-154)

Within their roles of caregiver, it was noted that the nurses were making decisions that had an impact on a patient's likelihood to receive timely health services. For example:

One of my greatest struggles, once I got into supervision and management was, "You do not have to be the person who prevents people from accessing something they firmly believe that they need, even if it costs money." As a Northern nurse, you were making those kinds of decisions. For example: if I thought my arm was broken and I needed to go to the hospital, but that nurse did not, she would not authorize the trip for me. There could be a conflict between the patient and the nurse. How is that person going to get what they have a right to and what they need? (25: 70-84)

From the above example, it was difficult for nursing supervisors to make health decisions about who received care and who did not. Making those types of decisions about their clients' mortality also placed moral distress on nurses, who were otherwise not prepared to carry that type of responsibility.

It was becoming evident that it was challenging for nurses to provide responsive and safe care without being fully informed of their client health needs. It was further challenging for nurses to prioritize the health needs of the community without meaningful consultation from the communities.

Community Access

Similar to patient accessibility, community access can also be a challenge for nurses providing health services to community members. Particularly, it was challenging for nurses to provide care to their communities if they did not see themselves as part of the communities. For example, the detachment of one's roles as a nurse within the community made it difficult for the nurse to connect with their communities. As portrayed:

As a nurse working within the community in my current role, I do not have as much direct contact with the community. I work with the Public Health nurses to help ensure that we are providing good service for the community. (13: 132-135)

Furthermore, it was difficult to provide effective care to their clients if nurses were removed from their clients, or provide care at an arm's-length distance. This separation between the nurse and client did not provide an opportune environment for nurses to be informed of their clients' health needs.

Additionally, the division in services based on one's location created challenges for clients to access health services in a timely manner. On reservation land, opportunities for health education lacked; for example, it was difficult for clients to reach optimal health outcomes when the services for healthy living were restricted and limited to 'on' reserve communities. As described:

In communities, if you do not work at the store or the school, there is no work for you. You would have to leave your community. If you are not willing to do that, because you cannot afford to leave or have absolutely no connection to anywhere else, then, there is no work. There is no industry there. It is a reserve. [Emphasis added] (9: 410-422)

As a part of their practice, nurses tried to develop relationships with their clients and communities. From the interviews, it was noted that some nurses were comfortable being care providers for their clients, whilst others were not comfortable with their public health roles. It seemed liked their comfort level varied with different levels of ease when working in their communities. The following two examples illustrated this point:

I was hosting clinics to have baby immunizations. My clinics were not well attended. People would say, "Oh, you are the new nurse? What happened to the one that was here before?" It was those types of comments that made you feel like you were the newcomer, and that you did not fit in. (20: 52-59)

Being here five years, I have developed a social relationship, but also a therapeutic relationship. There is a fine line to both. They all mesh together. It takes time to learn all those things, and to develop a relationship with the community. (24: 58-66)

The commonality in both examples was that building a trusting relationship with the community took time to develop. The challenge in developing a trusting relationship was that one's commitment to building these relationships may not be the same as others. This can impact the community, especially when experiencing high staff turnover. In general, when there was a lack of routine or inconsistency in staffing, it was difficult for nurses and their clients to develop a lasting and trusting relationship. Without that trust, it was difficult for nurses to engage their clients to follow health teachings.

In turn, nurses were becoming frustrated with the lack of cohesion among the communities. Specifically, nurses were frustrated with not being able to influence their client health behaviours. During the interviews, this point of wanting to control their clients' behaviours surfaced from the data. Trying to control the client behaviours or actions became a

source of conflict for those who wanted to force their clients to behave in a certain way. For example:

I remember a nurse was so annoyed because this person went to see the doctor in town all by themselves and did not make an appointment through the clinic. Well, the nurse was offended. She had her nose right out of the joint that this person took it upon themselves to make an appointment at the nearest medical clinic. I remember saying to her, "Well, what is wrong with that?" Never getting real satisfactory answers. [Laughs] (25: 91-100)

In the above example, the participant viewed community health services as being there for the clients and for them to have access to the services when needed. However, the above participant described her frustration of seeing how other nurses wanted to have control over when their clients would and should receive care. Health services should be available for the clients to access care when needed; however, this was not true if nurses viewed their roles as a gatekeeper to health services.

In linking the above examples to practice, patient accessibility and community accessibility allowed the nurses a point of entry to reach the public. This access provided the nurses with an opportunity to influence and control the behaviours of their clients. Furthermore, the relationship of controlling their clients' health allowed nurses a way to manipulate their clients for mandated health outcomes. In further analysis, it was difficult for nurses to manipulate their clients' actions without having access to their clients and the community as a whole. However, nurses that did not agree with this way of practice were starting to become ostracized and isolated within their own practice as they were not following mainstream practice.

5.4.3 Health Education

Diagnosis, Treatment, and Management

Health education is a follow up to patient and community accessibility in that it can be challenging for nurses to provide health education without access to clients and communities. Specifically, it can be challenging to diagnosis and treat their clients without their clients seeking services. One participant offered that when clients come to the clinic for services, they were seeking out some sort of help. As described:

There is a baby that a mother has that has been sick for a few days. She came to the hospital to get advice and to get help in diagnosing the illness, and if there will be any intervention for the health of her child. Of course, they are not thinking in the term of interventions, but generally speaking, they seek something out. (5: 38-43)

Within this above example, the participant viewed diagnosis and treatment as a positive intervention for the mother and child in learning how to be healthy. Through interactions with clients, nurses were able to provide their clients with nursing care in working towards health promotion and preventative care. However, it was challenging for nurses to provide the medical interventions when their clients were not coming to the clinic for services. For example, one participant spoke about the difficulty of treating young men in clinics as they were reluctant to come to the clinic for testing, such as STIs and HIV testing. As described:

Especially with young men, because they do not come in here. We have a hard time targeting them with the smoking cessation campaigns. Of course, we have big addiction issues here. Young men are also concerned with being exposed to syphilis and HIV, but you just do not get them in here to counsel them on that and offer testing. (9: 257-266)

In the above example, the participant shared about the vulnerability that their clients faced in seeking out health services. This vulnerability was not only with clients coming to the clinics for help, but also with their clients having health issues where they felt stigmatized and demoralized for by others. It was difficult for clients to seek out services when the communities, in general, had a high rate of incidences for all diseases ranging from addictions to sexually transmitted infections. Overall, it was difficult for community members to reach out for help as, for one, they did not know where to go; as well, they thought it was normal to have these health issues. In this sense, being unhealthy became a state of normal health. It was frustrating for nurses to bear witness to progressive disease states by the time they saw their clients. As illustrated by the following:

Other than treating people when they come in and taking care of them here, we also try to educate them as much as we can about their condition and how to continue taking care of them when they go home. If they have diabetes or something like that, then, we teach them about insulin use and more kind of a healthy diet. We usually have a diabetic educator upstairs that sometimes comes down. A lot of times, just in between, it is good to kind of reinforce and keep them educated on what they should and shouldn't be doing. (7: 258-264)

In this example, health education was seen as an opportunity in helping to control the preferred health outcomes of their population. Moreover, participants described that when their patients came to the clinic, they treated their visits as an opportunity to teach them about health prevention regardless of one's presentation to the clinic or of one's health issues. This approach was seen as a 'catch all' approach, where the nurse educated the client on the issues that were not necessarily of priority or concern for the client. For instance:

They have a Falls prevention program on long term care. Every client that comes in is assessed for falls. Every client that is admitted on the detoxification ward is assessed for what risk for a fall. Every home care client is assessed. Every client on acute care is supposed to be assessed. Whether they are or they are not, I do not know the answer to that question. (24: 489-492)

The above participant was explaining how his program's direction can dictate how he should approach his clients in managing and treating their health issues. The delivery of health services became generalized to the social issues that the community was facing at large. Within this delivery of system, the client's health is not the focus of care, but rather the attention is focused on trying to manage and control the diseases stemming from social health issues plaguing the communities.

Complex Care Needs

Through the data analysis, it was becoming evident that nurses were treating clients for health conditions that were often rooted within socio-economic and political issues. It was challenging for nurses to treat and manage health conditions where the etiology for the illnesses were linked to the determinants of health, usually related to the impact of colonization on health. Furthermore, it was difficult for the nurses to treat diseases where they had limited skill sets, or when the treatment of care needed was beyond their knowledge base. For example, treatment of care often did not address social determinants of health. As one participant described:

Population Health strives to address determinants of health and to reduce health inequities. You are using the population health approaches and helping to build capacity within communities for

people to look after their own health needs, helping to reduce barriers, and access to care. (17: 136-139)

With the complexity of health issues, it was difficult for nurses to feel like they were capable and competent to treat and manage complex cases. In providing Northern health services, specifically in outpost nursing stations, nurses were often providing health care services by themselves without support from their colleagues or supervisors. Given the situation, it was important for nurses to have a strong clinical knowledge of advanced nursing practice. However without proper orientation to Northern communities, it was difficult for nurses to effectively manage their portfolio. As demonstrated by the following:

In the outpost sites, nurses are independent. They do not have physicians up there for a good portion of the time. The nursing staff has to be familiar with the management of these patients, and it is very hard as a physician to sometimes get a history. In an emergency scenario, nurses are managing the patients themselves. (10: 80-88)

Some nurses, who did not have a good orientation, were just pressured to work here. They were threatened, and then they think that this is not their cup of tea. So, they run away. [Emphasis added] (23: 466-469)

In both examples, the participants spoke about the diverse experiences that nurses were exposed to while working within rural and remote Northern Canadian Aboriginal communities. The first example reflected upon the challenges of nurses working in the North without adequate resources. Additionally, it was challenging for nurses to understand complex health conditions without having the basic nursing knowledge to build upon. This created challenges in treating clients with complex care conditions, specifically, in being able to

communicate patient history and identify key pieces of information in order to make critical life-threatening decisions.

The second example brought forward that with the intensity and complexity of care involved, it was difficult for nurses to want to stay and practice within their communities. Although nurses were willing to work in the communities, without proper orientation and resources, their willingness to stay diminished with continual exposure to their clients' health issues within the communities.

Additionally, it was noted that senior nurses drew upon their experiences of what they have witnessed throughout their practice. Although they felt that there was some progress throughout the years, they also felt that change was gradual, and in the end, not enough. With over thirty years of practice, one participant explained:

People do not have broad enough exposure to changes in nursing care that is going on. This includes even palliative care. People do not always understand good pain management. So, their patients are not getting enough pain medication or the proper kind. (25: 506-514)

Look, our nurses are doing these things. They are functioning like physicians. They are prescribing medications. They are prescribing treatment plans. They are doing all kinds of emergency services. They are ill-prepared. The Saskatchewan Registered Nurses Association (SRNA) took that and with SIAST, and Wascana said, "Develop a program." Within a few years, we started having people who were much better trained in the North. (25: 724-729)

In Northern communities, nurses were in charge of providing care for clients with complex health needs that were usually above their scope of practice. Managers and key informants expressed that their staff were not well-prepared in caring for clients with complex

care conditions. The implications of being 'ill-prepared' within practice related to nurses not effectively managing their client disease process. It was further challenging for nurses to work towards restoring health when the disease process was too advanced to treat. Furthermore, lack of response to clients' health needs could have long-lasting impacts on health and longevity, as harm cannot be reversed.

Nonetheless, to effect change, there needs to be communication pathways that are developed to open avenues for reflection, build community capacity, and call for action. Nurses can be agents of change if they are aware of their roles and challenges, and work consciously towards making a difference for the benefit of both themselves professionally and the health of their community. The next section, *Mobilizing Pathways*, addresses how nurses can be agents of change in working towards addressing identified gaps and building upon strengths within the communities.

5.5 Mobilizing Pathways in Aboriginal Health

In the previous sections, the focus was on identifying the roles and responsibilities of nurses working within rural Northern and Aboriginal communities. The roles and responsibilities were analyzed utilizing Critical Discourse Analysis. The findings revealed that nurses' challenges within Northern practice were related to the flaws of the structural system in which they worked. Furthermore, the challenges were also related to how nurses had viewed their clients, and to the value that they placed on their client worth within society. As well, their judgements often pertained to whether they thought the delivery of health services would help save their clients from the life that they were living.

From the data analysis, it was becoming apparent that nurses were frustrated with the poor health status of Aboriginal peoples and of those within their population of care. Some nurses were trying to understand the reasons for why their clients had poor health compared to other areas in the province. Other nurses tended to be defensive about their own positions and actions of treating their clients as though they were different from them.

There may not be a right or wrong way to providing care for their patients; however, an approach that is inclusive of clients can lead to better population health outcomes, and thus be the more beneficent approach to take. Such an approach can help nurses work toward improving health outcomes for their clients and communities. In the sub-themes that follow, nurses are working toward developing tools to provide responsive and respectful care for their clients, ultimately improving population health outcomes. This section emphasizes that the spotlight is not on the poor status of health outcomes for Aboriginal peoples, but rather on how nurses can help in mobilizing pathways for Aboriginal peoples' health.

5.5.1 Reflections

Self-awareness

During the data analysis, *Reflections* was part of the last theme that emerged from the interviews. In particular, self-awareness was a sub-theme that was a part of reflections. Participants had described their frustration in that with all the varied health issues facing their communities, they felt hopeless in not being able to know what to do nor how to contribute in a meaningful way to decrease the health inequities. Some of the participants

felt that they did not have the expertise to be able to address the health issues that their clients were facing on a daily basis. For example:

Again, limited experience. But, from everyone that I have spoken with and from the attitudes I have gotten from everybody, there is a huge desire to make sure nobody falls through the cracks as much as it is in some people's power to do. (5: 444-448)

I hate feeling that way as a nurse. I just do not know what to do. [Emphasis added] It is the worst feeling. It is a huge barrier. (5: 502-503)

In the above example, the participant described how she felt she lacked the experience to help her clients, resulting in her feeling powerless from not being able to make a difference. Similarly, nurses felt like they were struggling with their job requirements, and that their clients were suffering due to their lack of expertise. For example, the nurses were not performing to the best of their abilities because they lacked the experience and expertise in being able to care for their clients. As stated:

Suffering because I am ill-trained? The patient. [Emphasis added] There is no good training system right now in Saskatchewan for us. It is all by distance, you have no option. There is no in class IV program you could take if you wanted to. I could read a book, does not mean I have learnt everything or I have the same knowledge just because I read a book. (1: 594-598)

Another part of self-reflections was gaining understanding of what motivated nurses to become nurses, and how does one's motivation impact the care they provided to clients. For instance:

During nursing school, I did take some classes that were available in working in developing countries. I kind of followed that interest in my career path. (17: 24-27)

For this participant, nursing in Northern Saskatchewan was equivalent to working in a developing country. Furthermore, she viewed her roles as a nurse as providing missionary work to the less fortunate or the less civilized. Nursing care was a way to change people that were considered to be uncivilized, and teach them how to be civilized. To further elaborate, nursing care was not necessarily about taking care of people, but rather about changing people to be elevated within society. As described by another participant:

A lot of people go into nursing because they want to take care of people. That is maybe paternalistic. I would rather think about nursing as a way to help people make choices about their own lives and to kind of give them the tools that they need in their lives to make those choices. If we are able to do that as nurses, then that is probably the most effective things that we can do for people. (18: 127-133)

As seen from the interviews, there were variations in the motivation for participants in wanting to become nurses. However, there was a general consensus that nurses wanted to make a difference in people's lives. The lack of consensus pertained to whether one's limitations and lack of knowledge should be an issue for practice if it negatively impact population health outcomes. One participant spoke about how performance evaluation can be useful for nurses to identify their own areas of growth and development, which, in turn, can have a positive impact on their clients' health status:

One area that we have fallen short on is in doing regular performance evaluations, helping people see where they are, helping them to identify what their skills are, helping them to look at what they would really like to move towards if they were given that opportunity. Then, I think we could also do some basic screening or for those folks who have those particular skills already in helping to enhance those. (22: 427-432)

In the above example, the participant felt that performance evaluation can have a positive impact on quality assessment and possibly risk management. Risk management is not specific to an individual client, but rather to the risk of not providing essential health services to the population as a whole. The benefit would be to help prevent clients, as well as the communities at large, from falling through the 'cracks'. For example:

Sometimes a lot of it can be missed and fall through the cracks. If we had a patient assignment I feel that with one person being in charge of one person's care from start to finish: medications, washing up, and doing dressing changes, you'd have a better outlook on their care and you'd be able to do a better job, because it would be a continuing process. (1: 88-97)

A resolution to help prevent clients and communities from falling through the 'cracks' can include being aware of one's practice and how to strengthen relationships between nurses and clients in working towards the same goals. The next section speaks to the nurse and client relationship not being contained within a vacuity, but rather situated within a structural system of rules and processes within society.

Structural Processing

Being aware of the challenges that are part of education and training can help nurses provide responsive and respectful care to their clients and communities. For example, one key informant offered that it was difficult to have separate training courses for physicians and then for nurses. He offered that for Northern health care services, the training should be equal and comparable for nurses and physicians.

One problem I see with kind of having the physician's course and the nurse's course, it is nice to have kind of the one

common standard and all the resources are common and you are speaking the same language in the management. A lot of other sites have kind of moved towards not saying: 'this is a nurse's course and this is a physician's course.' (10: 98-103)

Another challenge that needed to be addressed was that some staff were not up-to-date with technology training, which created challenges by not knowing how to access the right information. For example:

We are working right now on implementing our MDS program. It is a computer program, it is an assessment program. It is already provincially done. We are building our program to tap into theirs. Let me tell you it is tough when you are not 'techy' and you have to listen to all these technological guys. (14: 664-667)

In this above example, the participant offered that it was difficult not knowing how to use the MDS (Minimum Data Set) Training and Education program, a computer software program used to monitor patients' charts, complete patient assessments, and record information from patient admission to discharge. The program was being used provincially, yet the Northern communities were still in the planning phase of implementation. This builds upon the demand for nurses to have funding for programs that are needed within their community, rather than 'tapping' into programs used by other areas of the province.

As described:

More educational funding would be wonderful for nurses. Not for any particular illnesses, just general funding. I have not had very much specialist training at all since I have been here. At times, I feel out of sort. I would like a chance to do some more studying. (11: 369-375)

From this example, the participant explained that general funding would allow nurses a way to self-direct their learning needs and address those needs with the appropriate resources. In the

above examples, it was evident that nurses did not have access to resources that they needed in providing essential health services. These issues can be related to their lack of influence in making decisions about educational and training programs.

Additionally, another structural resource that nurses were frustrated with was the lack of current policies. Some of the participants found this to be challenging because their policies were 'outdated' and this could have implications to providing safe patient care. For example:

Have you looked at our policies? Some of them are outdated or we do not have any IV push policies whatsoever, yet we do a lot of IV push medications. How can you be practicing something and feel safe with your license, if there is no policies to back it up? We steal, not steal, we photocopy a lot policies from other health regions, but we do not officially adapt them as a hospital here. This is not going to help you if you have to go to court. (1: 538-547)

With a lack of current policies within the workplace, nurses felt vulnerable within their delivery of practice. More poignantly, participants felt that a lack of current policies exposed them to unnecessary liability. From the above example, the participant offered that her health region did not have policies that were specific to their district; instead, they stole from other health regions or provinces for policies. The issue with borrowing from other health regions and provinces was that the policies may not be applicable to the present health region, and hence, could influence nurses to provide care that may be harmful to their patients.

Nurses were susceptible to providing unsafe and unregulated care in an otherwise regulated and licensed professional body of practice. In addressing these challenges, one

participant argued that there was an opportunity for change if one can understand the difference between leadership, management, and supervision. Specifically, the distinction can help guide nurses to provide care that meets the health needs of their clients. As illustrated:

You have to understand there is a difference between leadership, management and supervision. These are three different skills and three different parameters of keeping an organization running. You have got to have all three. Leadership sets a vision and direction. Management makes it work. Supervision sees that it works. (25: 557-562)

For this participant, the three roles were interconnected in creating an environment that maintained a healthy structure and function within the organization. Without these elements, nurses can be at a disadvantage in providing health services in the best interest of their clients and communities.

5.5.2 Community Health Capacity

Inter-sectoral Collaboration

This section, Community Health Capacity, builds upon Reflections as a next step in mobilizing pathways in Aboriginal health within rural and remote Northern communities. Building community capacity can be used as a tool for planning, as well as building and reflecting on strengths in working towards community-based goals. One of the elements of building community capacity as discovered through CDA was inter-sectoral collaboration. In the delivery of primary health care and public health services, inter-sectoral collaboration can be

used to help various teams work together to complete common goals, often seen with community-based projects.

Inter-sectoral collaboration can play a significant role in mobilizing pathways in Aboriginal health by introducing the concept of shared responsibility for health among all community stakeholders. Various community stakeholders can include nurses, physicians, allied health care professionals, administrators, and executive leaders, as well as patients, families, and communities. Inter-sectoral collaboration can be beneficial in helping nurses work with other agencies to meet community health needs by utilizing appropriate programs and resources. For example:

The funding and some of the projects that we can reinforce or that we can partner up with so many different agencies for a variety of programs, not just myself, but, also for tobacco cessation. There are a lot of good things that come out of this unit. In the dental health program, you have a dental health educator that supports and represents the North. (13: 606-610)

Additionally, working within teams can be beneficial to frontline staff in providing nurses with the resources that they need to meet the community's health needs with responsive care. Being aware of community resources can help nurses feel like they are appropriately equipped to meet their clients' health needs. However, from one participant's perspective, it takes more than positive encouragement. Inter-sectoral collaboration takes effort in reaching out to other teams and working together towards a common good. As explained:

I could also offer like positive feedback, but I think they need a little bit more than that. [Laughs] I think it is more, using more of a team approach. And, getting to know what other support

systems are available out there that will help the clients. (6: 342-350)

Furthermore, working towards meeting the community's health needs takes commitment from all stakeholders in order to be invested in creating a partnership. Partnerships can add value to community health in creating opportunities to network where resources might not be accessible, available, or affordable otherwise. Developing partnerships can help nurses feel like they are contributing to their workplace in a positive way, ultimately working towards improving health outcomes for their clients and communities.

In the following example, the participant explained that there was an emerging partnership among Northern stakeholders called the 'New North'. One potential benefit of 'community as partners' includes public policy development, which could help nurses to navigate the interrelated relationship between determinants of health and health outcomes, and intervene in a meaningful way. For instance:

Part of the partnership is the 'New North', which is a collaboration of Northern municipalities. Speaking with them about what they can do to have better public policies will make it easier for communities to build their communities. For example, some of our staff are working on food costing. This information goes out to social services. It is used to look at where there should be food subsidies. (17: 156-164)

In providing inter-sectoral collaboration, one participant described that working together as a team can help improve their client health conditions. Specifically, in primary health care, providing inter-sectoral collaboration was a shared responsibility among disciplines and departments. The client benefited in that he or she had one point of entry, and inter-sectoral collaboration increased the point of entry for multiple services. In general,

integrated health services can help health care professionals to share their knowledge and expertise by working together to meet their client's health needs to their full capacity. For example:

We realize the importance of primary care, and perhaps how we are not as effective as we could be. However, the South has a harder time connecting maybe their fee-for-service physician with their RHA (regional health authority) employed dietician and a private sector physiotherapist (...) this would be who the client considers as their primary care team. How do we build a system or redesign our system with the intention of helping to connect professionals? (9: 92-102)

For harm reduction programs, we have different agencies. We have different agencies within communities coming together to share ideas. To collaborate on what is working well in the community and what is not. (20: 700-705)

From the above examples, inter-sectoral collaboration can play an important role in working together for the shared interest of optimal health and treatment for clients. This can be helpful especially in cases of complex health issues where specialized care and knowledge is needed for treatment and management of diseases. Inter-sectoral collaboration can help nurses to feel reassured in providing an optimal level of health services to their clients and communities.

Community Engagement

Similar to inter-sectoral collaboration, *Community Engagement* was another tool that can help nurses build community health capacity within their communities. As identified from the data analysis, it was essential for nurses working at the frontline level to connect with their communities, and for the communities to feel included within care. Specifically, participants

offered that Elders can play a significant role in providing guidance to the community, and to help encourage community members to be involved within their own care. The purposeful act of nurses consulting with Elders was seen as a respectful way to provide culturally safe care to their clients. Benefits included nurses were providing care that was respectful of their client health and cultural needs. As stated:

We work with to encourage people to attend health promotion events like an Elder or something like that culturally speaking, someone who they listen to and who can give direction. (5: 366-368)

We have a couple of Elders that work within the addictions team. They offer Native spirituality as the more well uniformed services for addiction, et cetera, and people within our system. If they have an interest in this, there can be access to an Elder. (11: 296-299)

Mentorship from Elders can help nurses to gain a better understanding of community health issues from the community's perspective. Additionally, nurses can apply their new knowledge in helping to improve their client health outcomes through meaningful care. This can help nurses feel like that they are connecting with their clients, the Elders, and the community. In turn, this can also help clients feel connected with their nurses and other health care professionals.

Within this study, the essence of building community health capacity was strengthening the nurse-client relationship. This was achieved by making the nurses and clients feel relatable to each other. For example:

We hear lots about being non-judgmental and client-centred care. It is important not just to pay lip service to that, but to figure out how to park your own values. The clients that are

happiest with me are most satisfied to be my clients because they can come in and say: "You know what, I yelled at my kids." They want to know that I can validate for them that we all have struggles (...) there has to be some kind of emotional connection. (9: 288-308)

Creating a connection between nurses and the client was important to help clients feel like they can relate to their care provider on a personal level. This action helped encourage clients to ask questions and learn from their care provider on a 1:1 interaction. The benefit of nurses being relatable to clients helps clients feel at ease and perhaps less judged by their health care provider.

In the previous example, the participant expressed that nursing care can be effective when they create a connection with their clients. It was a helpful means to broker knowledge about health when there was a relationship base between the nurse and client to build upon. In further analysis, understanding what the nurse and client might experience on a personal level can help create a sense of trust. Trust building can be useful in developing a sense of cohesion between the nurse and the client, where nurses and clients are working together as partners in health.

Another participant in a remote nursing station offered that it was difficult to connect with communities due to the geographic isolation related to Northern community living. However, utilizing radio communication was one way to connect with clients. This unique way of connecting with the community helped provide relevant information to meet community health needs in a responsive way. As illustrated:

We use the radio to educate the public. For example, this month we will go, like this morning, like at 10 o'clock we went to the radio station to talk about addictions. We talked about the

challenges we have, sending people for detoxification, and what addiction is doing to our community. We have different teams every month. And we will focus on that. Next week, I will talk about tobacco and gambling. Then, we will encourage a community to call the radio station and ask questions. It is those little things that make a difference. (23: 486-496)

In the above example, the participant reflected upon that each life has value, and that using appropriate teaching and education strategies is an ethical way to meet their client health needs. In particular in this community, there was a high illiteracy rate and it was difficult to deliver teaching resources in written form as it would not be effective to the community. The delivery of educational resources through oral communication such as a community radio allowed clients to have access to health resources in a responsive and respectful way. Community engagement was used in a variety of ways to help the nurses connect with their clients in a meaningful way without the clients feeling like they were being judged by their care provider. This connection can help to broker health knowledge, as well as to help build community health capacity from the community's perspective.

5.5.3 Call to Action

Advanced Nursing Practice

Through *Mobilizing Pathways in Aboriginal health*, the last theme identified was *Call to Action*. In this section, the two sub-themes that were helpful in mobilizing pathways were advanced nursing practice, and developing and regulating standards of practice in delivering isolated Northern health services. Particularly, the participants offered solutions that can help address some of the challenges that nurses were exposed to within their practice. For

example:

We have had some nursing staff come down and work alongside our physicians in the emergency department to try and enhance their skills. It is a skill that some people have a little bit innately that it is just easier for them and I think something about that can be learned or enhanced too, but our outpost nurses will often time struggle with that. (10: 730-735)

Working with advanced clinicians can help nurses to gain the knowledge and skills needed to help them provide safe and competent care based on their population's health needs. Another area of knowledge that was identified was the need for current education. It was difficult for nurses to be current with their training without having nurse educators to help advocate for continuing education components. As described:

We have adequate physicians. We do not have a nurse educator. We have nobody that is keeping us up to date. In the past, we've had a lot of challenges with just trying to do continuing competency things, because of staffing. It is hard for us to go out and get the training. The training isn't offered very much. Communication is an issue. (24: 382-386)

From the interviews, participants spoke about wanting to do better by their clients. As part of their cultural training, it was mandatory for nurses to attend a four hour Aboriginal awareness program. This training can be helpful in making staff aware that cultural care is part of providing safe and competent care for their clients. However, the training was not extensive and did not cover all areas of cultural knowledge specific to communities. As illustrated:

Being aware and being open to be reminded about that, I mean, all of the staff go through a short, a four hour Aboriginal awareness program. It is a mandatory thing. (17: 231-235)

Another participant spoke about the importance of being self-reliant within nursing practice. Self-reliance spoke to the need for nurses to be aware of their own knowledge gaps and how to acquire this knowledge in order to provide optimal health services for their clients. Ongoing learning allowed nurses to be responsive to their client and community's health needs. For example:

It would help to be independent in your own learning and in charge of improving your skills. It is important not to have an attitude like, thinking that you are smart and you have learned it all or you cannot improve on skills. Being open to learning new things is really important, because every day, it is a constant change, and how you think and what you know and stuff. You need to build on that to be able to work here and keep up with skills. (24: 122-131)

Continuing education helped nurses feel confident about providing safe and competent care within their practice. Specifically at outpost nursing stations in rural Northern communities, it was important for nurses to be self-reliant on their own assessment and evaluation of their skills, as it was difficult for nurses to seek out guidance when they lacked the resources to help them direct their professional practice development.

Within the North, nurses needed to advocate for their own learning, and be creative in addressing those needs with the current resources. However, the challenge was that nurses did not feel like that they had access to the resources that they needed. For instance:

Licensed Practical Nurses (LPNs) are not given any home care nursing and community health nursing education. The LPNs have no education in anaphylaxis management. One LPN said to me this morning, "Take this out of the bag because it is too heavy" for me to carry. She said, "Well, would I be allowed to give any injections anyway? Am I allowed to do that?" I have been on this

for about nine months, trying to get somebody in this building to teach anaphylaxis certification. (15: 352-368)

In the above example, the nurse was frustrated with the lack of consistency in nursing education and the life-threatening impact that this can have on client care. Clients and the public have a reasonable expectation that nurses are competent and certifiable; however, nurses from lack of training could not be bondable if they were practicing below the expected standards of practice.

Standards and Regulations

In general, the implementation of standards and regulations can help nurses to feel like they are providing safe and competent care. Within the North, it was difficult to oversee that the standards and regulations were met when there was a lack of managers and directors to supervise the staff's day-to-day practice. Furthermore, the nurses felt that there was a lack of supervision in evaluating their performance. As explained:

What [is] best practice? I do not often know that. I do not really have a background with HIV, so I kind of know where to look. But there is nothing that I found, so far provincially that says this is what you should do. It is a standard of practice that you should monitor Communicable Diseases for counts every three months on somebody, once they start medications. I know it is recommended, but there are no standards of care. [Emphasis added] (18: 448-453)

The lack of standards of care became the status quo for Northern nursing practice. One participant offered that she usually practiced by herself and that it would be helpful to have someone help guide her. The guidance from educators can help nurses to feel confident and competent within their practice. For example:

It would be good to have another person coming in and helping to inspire and we could share things because you do feel like you are on your own. I have been a on my own a lot in my career. It would be professionally good. (15: 263-267)

Without regular supervision, it was difficult for nurses to be optimistic about providing safe and competent care to their clients. Participants described that, generally, they felt alone.

Additionally, participants felt vulnerable with making legal and ethical decisions. They felt like they lacked the knowledge to make ethically-sound decisions. Without having standards and regulations in place, nurses felt that they were at a disadvantage to make the right decisions for their clients. For example:

We just need to do our best to not cause harm to anybody. Yes, there are legal and ethical issues. I would say that we need the same treatment. I mean treatment as in like the same access to things as the rest of the country. There has to be quality in those accesses. And, quality does not necessarily mean quantity, but it is based on a situation. Because we are isolated Health care professionals, we need to be looked at as, "Okay, these people have certain challenges and we would not expect someone of the same position in the city to be doing the things that they are doing." Because we are isolated and forgotten about isn't an excuse to do that. They are putting us in a situation where legality is an issue. We are constantly in a struggle with our own ethics as far making decisions, fighting for our patients, fighting for the appropriate technology we need, and fighting to have updated equipment. You know? (24: 242-253)

In the above example, the participant felt like the system was placing them in situations of negligence. In particular, he was angry that they were not a priority for the system.

Nurses also felt like they were not treated equally, as compared to their counterparts in other parts of the province. For instance, many of the nurses working in the North had

worked in other parts of the province, and so they sensed when the standards were not equitable. As illustrated:

I had a lady who was palliative in her home. One of the nurses told me that we needed to inform the Royal Canadian Mounted Police (RCMP) when our client died. I called the coroner, other nurses, and the doctor. I asked them what their stand was on this, whether I needed to do that or not. I did not really get any answers for sure. I ended up informing the police. They said, "It is part of our policy that we go and do a small investigation." I said, "Since when do police investigate somebody who is dying their death (...) there is no way this is a policy. You guys go investigate every person that ever has died?" [Laughs] I refused to have them go. They went anyways. [Laughs] It turned out that they had no right to be there at all. (24: 135-175)

In this example, the participant was critical about directions from so-called authority figures. He felt that the legal and ethical principles in Northern nursing practice should be the same as it is anywhere else in the province or country. Practicing in the North did not mean it called upon abandoning the principles of legal and ethical nursing care. For this participant, he tried to maintain his principles of legal and ethical care despite his challenges of not having clear standards and regulations. His commitment to his practice was based on his commitment to his clients.

Another consideration in maintaining high standards and regulations in practice was to have an evaluative system to monitor competent and safe care. The outcome of this process was to have a well-run health care system that focused on improving the population's health outcomes. However, when there was a lack of leadership, it was difficult for nurses to maintain a high standard of care. The posed challenge was in connecting policies to practice, and

practice to policies. One participant described that it was challenging for frontline staff to follow through with policies within their practice. As explained:

One of my nurses said: "By the way, I gave your patient his pain medication. I have not charted it yet, but I will do that right now." It was not charted in the book and it was not charted in the narcotic book. This is what creates bad feelings. It is bad for the patient. If people do not talk in a factual and objective way, then the patient suffers. There were more incidents than that that I care to even remember. (25: 465-472)

The participant was frustrated with how the lack of self-regulated practice can negatively impact client care. This contributed to nurses feeling like they were at risk of providing harmful care to their clients.

Furthermore, this participant felt powerless in not being able to generate change with the impact being that clients suffer. The lack of adherence to standards and regulations also created challenges in developing a trusting relationship between the nurse and client. However, this might not be applicable to nurses who did not value the health of their clients. In this sense, the delivery of Northern health services did not always have to be tailored to meeting their client's health needs.

In general, adhering to standards and regulations can be helpful in maintaining a sense of normalcy in the operations and function of the health care system. However, when the standards and regulations were lacking in practice, it was difficult for nurses to feel motivated and accountable to their clients. From the data analysis, it was revealed that without consequences in the workplace, accountability to clients was limited. Nursing care was not focused on improving clients' health outcomes, rather the delivery of Northern health services became centred on nurses trying to survive their environment. Essentially, nurses were

bearing witness to the suffering of their clients by not being able to improve their client health outcomes with much success.

5.6 Résumé

In summary, the participants were candid by expressing their emotions and vulnerability about themselves in relation to their clients, workplace, and communities. It was also noted that many of the participants laughed during the interviews. For, some participants were surprised by their own answers. Upon feedback from the participants, they brought forward that they spoke authentically about their experiences of working in the North. This was the same for new nursing graduates to senior nurses. It was also the same for nurses that identified themselves as Aboriginal and non-Aboriginal Canadians. The impact of working in the North seemed to be long lasting for nurses, even years after interactions with their clients and communities. In the following section, the major findings of the data analysis are presented in discovering the roles and challenges of Northern nursing practice.

Within this research study, three significant findings emerged from the data. The first finding of significance as it related to these objectives was that the Aboriginal person's identity was constructed in relation to the nurse's role of delivering essential health services. Specifically, the Aboriginal person was a person in relation to the colonized society, and nurses played a role in governing Aboriginal peoples, including First Nations and Métis people for purposes of the state. In this study, Aboriginal peoples (the colonized) did not exist without being in a relationship with their nurse (the colonial agent).

Within these Northern communities, the existence of the colonized did not stand alone from their colonizer or agents of their colonizing state. Thus said, a condition of existence of being 'Aboriginal' was placed upon the individual. In particular, the Aboriginal person did not have autonomy over their health entity, as they were dependent on their colonizer for their existence. From this position, nurses were acting as agents of the state in enforcing the Aboriginal person's identity as being subjugated within a colonized society. Moreover, Aboriginal peoples seeking health services did not have autonomy over their health affairs, as they were dependent upon the State for the delivery of health services.

As informed by the research data, the second finding of significance in this dissertation was that nurses were not treating the 'ill' patient, but rather treating the patient for being 'ill'. Indirectly, participants considered the state of being 'Aboriginal' as the focal point for treating illnesses and managing diseases. As a collective group, nurses were concerned by the state of their clients' poor health status. In turn, they needed to maintain a boundary between themselves and their clients. Specifically, the nurses needed to maintain boundaries between themselves and their clients' 'body of illnesses', i.e. the 'Aboriginal' body. In particular, nurses were unable to distinguish their patient having an illness from their patient's identity of being 'Aboriginal.' There was no distinction between the 'subject' and the 'object.'

These generalizations further assumed that Aboriginal peoples had poor health due to determinants of health, which became accepted as a status quo. Furthermore, being 'Aboriginal' was perceived by the nurses to be biogenetically shaped by social deterrents of their client's health environment. Relevant to nursing care, participants expressed that the

poor health status of an Aboriginal person was part of the normative health standard for Aboriginal peoples. In this light, nursing care did not focus on preventative health care, but rather on treating illnesses and managing diseases by treating the client for their perceived racial variants.

Furthermore, similar to the second major finding, the third major finding of this research study included treating the Aboriginal person for being 'Aboriginal' by separating the patient from his or her identity. The treatment involved reforming the Aboriginal patient from the condition of being 'Aboriginal'. For example, nursing care had taken on the role of the modern day missionary of the North. Analysis of the data revealed that participants thought the pathway to Aboriginal peoples' health included their patients' ability to conform to colonized ways of living and civility.

Within their roles of working with isolated Northern Canadian communities, nurses wanted their patients to conform to rules that were defined by colonial laws and regulations. Moreover, the Aboriginal person was often not aware of the colonizing rules that were superimposed on them by the state. In this sense, the marginalized population was further marginalized, as they were expected to conform to rules that they were not aware of, nor did they agree to follow.

In particular, nurses were enforcing their patients to be civil and healthy if they followed the same rules of conduct that were expected of them within society. However, the majority of nurses were not exposed to different cultural ways of living or knowing. Nurses primarily lacked the knowledge based in community traditions to help their patients achieve health and wellness as defined by the patient, and relied more upon colonial

knowledge of what was considered health normalcy. As so, the Aboriginal person's sense of self and success for health was controlled by external constructs. Essentially, the power for the opportunity to health was controlled by the actions of the nurses in trying to convert the Aboriginal patient to be the 'patient'. To aggravate this further, Aboriginal peoples can be offered a chance for salvation if they follow civilized ways of living.

In summary, data analysis revealed that the majority of research participants connected with their clients on their terms as colonial agents, rather than on their clients' terms. Additionally, nurses can contribute to the oppression of health equity for Aboriginal peoples by constructing an image of the Aboriginal person that, now, carries meaning in the dominant society. Predominately, nurses were concerned in protecting their own interest and self-worth. Specifically, they needed to maintain the status quo to not be assimilated with being the 'Other.' The colonial agent did not want to become a colonial subject. Particularly, the participants did not want to be seen as 'Othering' through their roles and duties as health care providers, given the risk of becoming the 'Other.' With a shift in pastoral power to institutional power, nurses exerted effort within their roles as colonial agents to primarily 'civilize', and then 'save' Aboriginal peoples.

6. Discussion

My primary [paint] brush is Ojibway. My secondary brushes are the Northern Swampy Cree. All my brushes have names. The Cherokee brush was always my favorite. My Indianness is deep within me.

- Arthur Shilling, 1986

Arthur Shilling was a respected Indigenous artist whom contributed to the canvases of Canadian Native artwork. His work is internationally recognized for exploring Native experiences in the life around him through depicting the faces of his people (Newlands, 2000). He was also known for using bold strokes of colour in portraying the proud defiance in the faces of his people. However, his pride in his Native heritage was not often shared by the dominant society. In this research study, the majority of participants did not necessarily view their clients' Aboriginal identity as a source of pride. For, the majority of nurses saw the life of a Native person as being detached from the dominant society.

Nurses also saw that their clients' lives were plagued with poor health outcomes, complex health conditions, poor living conditions, and violence within their impoverished communities. As revealed from the evidence, nurses working within these vulnerable communities were placed in a position by the state to treat illnesses and manage diseases of Aboriginal peoples for purposes of the state. This proved to be a daunting task, and possibly an unfair task, for nurses as they were ill-prepared in caring for a colonized population.

As provided in Chapter two, the literature review offered that Aboriginal peoples have experienced many social and health hardships, mostly in part due to colonialism. In

addressing these contemporary issues of colonization on Aboriginal health, nurses were not often aware of the roles that they played in delivering health services within a colonial health system to their clients and communities. For, nurses needed to maintain a separate identity from their roles of caring for the 'Other'. As well, it was important for nurses to maintain separation from their clients so they would not become assimilated with being the 'Other', nor risk losing their position of power within mainstream society.

6.1 Major Findings

During this research study, participants were expressive about their attitudes and judgments about their clients' health conditions within these vulnerable communities. One expression included that nurses did not see their clientele as a population of people, rather as a population of 'Aboriginal(s)'. Being 'Aboriginal' became a state of personhood that represented poor health and potential loss of life within mainstream society. Through Critical Discourse Analysis, there were three main findings that suggested that the nurses were part of the colonial system of health services delivery within rural Northern and Aboriginal communities.

In this chapter, the major findings that were revealed in Chapter Five will be considered in relation to the Literature Review (Chapter Two), as well as to the theoretical approaches as discussed in Chapter Three. The three main findings from the data analysis were (1) *The Colonial Nurse-client Relationship*, (2) *The 'Aboriginal' Construct*, and (3) *Protecting the Segregated State*. These findings will be discussed in connection to integrating theoretical perspectives offered by Frantz Fanon, Julia Kristeva, and Michel

Foucault. Please refer to Figure 2.1 for the *Major Findings*. Although each finding was discussed separately, there were commonalities among the discoveries that overlapped with each other.

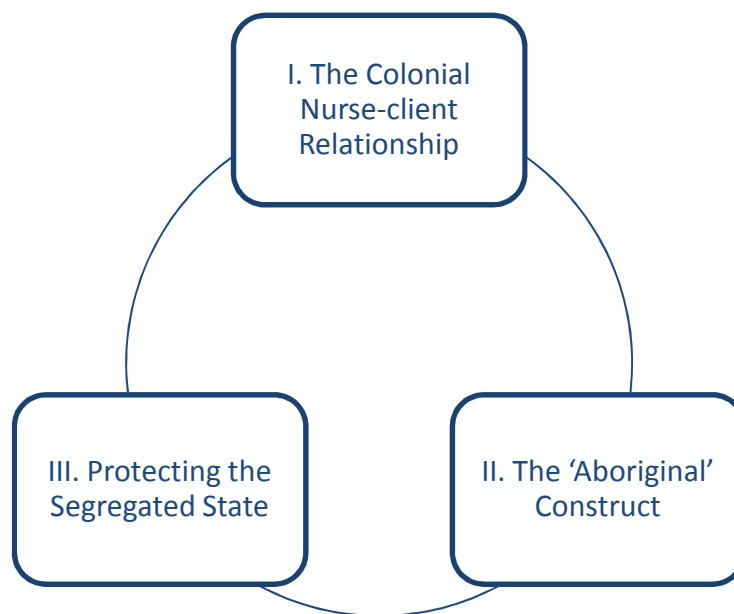


Figure 2.1:

Major Findings. © Zaida Rahaman, 2014

6.1.1 The Colonial Nurse-client Relationship

The first major finding of this research study revealed that the nurse and the client co-existed as one entity within a colonial state of being in rural Northern and Aboriginal communities. The nurse-client relation was an example of colonial relationships as seen in the delivery of Northern health services to Aboriginal peoples whom were dependent on services for care. The Aboriginal person (the colonized) did not exist without being in a relationship with their nurse (the colonial agent). This relationship of the Aboriginal person

and the nurse is similar to Fanon's concept of the 'master' and the 'slave', in which case the 'master' and 'slave' become one entity, for the identity of the 'slave' does not stand alone from the 'master.'

As Fanon (2008) described, "not only must the black man be black; he must be black in relation to the white man" (p. 90). Additionally, without the 'master' the 'slave' cannot exist, nor can the 'slave' place value on his/her own existence as he/she does not have a memory of his/her existence (Honenberger, 2007). The value of the 'slave' comes from being in a relationship with his/her 'master'; and so to paraphrase, the colonized can only exist when in a relationship with the colonizer. Similarly, in this research study, the Aboriginal person existed only as an Aboriginal person in relation to the nurse, for the identity of the colonized is shaped within their relationship with the colonizer or in this research study, the colonial agent of the state. However, part of the nurses' frustration was trying to navigate through colonial systems with the role that they inherited from the state.

A complex relationship exists between the colonizer and the colonized where the colonizer becomes dependent of the colonized; this can include the relationship between the European settlers and Aboriginal peoples (RCAP, 1996b). The impact of the relationship between the colonizer and the colonized can be complex rooting from the historical trauma of colonialism on Aboriginal peoples. The impact to Aboriginal peoples including First Nations peoples included:

The effect of social suffering, unresolved psychological harms of historical trauma and culture dislocation that have created a situation in which the opportunities for a self-sufficient, healthy and autonomous life for First Nations people on individual and collective bases are extremely limited. (Alfred, 2009, p. 42)

The cultural insignificance of the colonized within a colonial relationship is true of a colonial relationship. In this light, the experiences and hardships endured by Aboriginal peoples can be insignificant to the colonizer, unless it affects the colonizer in some way. In further understanding the nature of colonial relationships, the meanings of colonialism are revisited. As described:

Colonialism, as it is understood by most people, consists in such things as resource exploitation of Indigenous lands, residential school syndrome, racism, exploration of lands, extinguishment of rights, wardship, and welfare dependency. (Alfred, 2009, p. 43)

Another definition of colonialism in relationship to the cultural loss of Aboriginal peoples' identity states that "colonialism is based on elemental violence: the taking of what is not one's to take and giving of what is not one's to give" (Rogers, Degagné, Dewar, & Lowry, 2012, p. 6).

In rural Northern Canadian Aboriginal communities, nurses were responsible for the delivery of health care services to their clients and communities under direction of the state. In terms of the above definition provided by Indigenous scholars, nurses did not identify themselves as colonial agents, for nurses that worked in rural Northern Canadian Aboriginal communities did not see themselves as the aggressor.

However, as an extension of the government, nurses can act as colonial agents in delivering health services to Aboriginal peoples. The delivery of health services did not become a legal issue, but rather a moral issue. Therein lies the ethical dilemma in that nurses' roles as agents of governmentality may not be aligned with their duty of care as regulated health care professionals. According to the Registered Nurses Act of 1988, the

practice of RNs means “the performance or co-ordination of health care services including but not limited to (...) observing and assessing the health status of clients, planning, implementing and evaluating nursing care” (as cited in Muzio, 2013, p.6).

As illustrated by this excerpt, nurses have a duty of care to their clients and communities. For example, “the RN must know the client population, client needs, the complexity of health problems and other relevant information (e.g. resources), in order to fulfill his/her professional responsibility of coordination of care” (Muzio, 2013, p.7). As colonial agents of the state, nurses did not necessarily act in the best interest of their clients, or were unclear as to ‘best-practices’ for patient care. Instead, they may lean towards acting in the best interest of the state, and in contributing to the protection of a segregated state. This can create a situation where the nurses were sometimes unclear as to their responsibilities and duties in providing health services to their population of care.

In further understanding the roles of nurses working within rural Northern and Aboriginal communities, it is important to remember that the direction of nursing care was directed by the Indian Health Services for many decades. Nursing care was utilized prior to World War II, but there was an increase of nurses’ deployment from the division of Indian Health Services for Indian people, under the direction of the new Department of National Health and Welfare (DNHW) (Drees & McBain, 2001). After World War II, there was an increase in nursing services within isolated Northern communities, specifically at remote nursing outpost stations. From this direction, “the Department of Indians Affairs attempted to manage and care for registered Indian peoples’ health using specially appointed Medical Officers, nursing, staff, Indian hospitals, and the assistance of missionaries” (Drees &

McBain, 2001, p. 47). In Northern communities, nurses were used as resources in helping to manage and care for Aboriginal health conditions alongside a network of other resources with colonial mandates. The direction for care under the Indian Health Services was “based on a moral, rather than legal, imperative (...) Not from legislative obligation, but rather as a moral undertaking to succor the less fortunate and to raise the standard of health generally” (Drees & McBain, 2001, p.47).

Under the direction of DNHWS, several key goals helped to direct nursing care in rural Northern Canadian Aboriginal communities. A summary of these goals provided by Drees and McBain (2001) included:

To provide a complete health service for these [Status Indian and Inuit] peoples (...) To “improve assimilation” of Indian peoples by supporting provisions against ill-health (...) To building facilities supporting Indian health care, such as hospitals and nursing stations (...) To share the expense of caring for First Nations by encouraging a loose network of support services offered by Provincial health departments, Royal Canadian Mounted Police, the Department of Natural Resources, Department of Transport, as well as Indian bands themselves. (p. 47-48)

From the above excerpt, it was challenging for nurses to be aware of the colonial history that shaped their practice and goals with clients, populations, and communities. For example, Participant (#24) who had questioned the investigatory authority of the RCMP into the death of his palliative client was not aware that historically the RCMP was an allied partner in delivering Northern health services to the communities. In general, the findings from the interviews revealed that nurses working in the North were at a disadvantage of not knowing the socio-political and historical influences of colonization on Aboriginal peoples’ health and

the partners that supported this system of care. Furthermore, their lack of knowledge also contributed to nurses not being aware of how their practice was shaped by colonialism, as well as the meaning behind the nursing roles within their Northern nursing practice.

In delivering Northern health services, nurses were part of the colonial system in treating and managing the health conditions of Aboriginal peoples. For the most part, nurses did not see themselves as colonial agents in treating and managing the health conditions of their clients. They were unaware that under the colonial health care system, their goal was to manage and treat the population for presenting ailments. This created conflict for frontline nurses as their standards of practice in nursing were not aligned with the directives of the Indian Health Services.

Nurses were also discovering that their goals were not focused on optimizing their clients' status of health outcomes. In particular, the needs of the colonized state outweighed the needs of the colonized client. That being said, the nurses were not conscious of their roles as colonial agents. They were focused on the stress and limitations that they faced within their workplace and communities, mostly in relation to the poor health conditions of their population. The nurses were not used to living under colonial conditions that the colonized were, though this was an ordinary state of existence for the colonized. As explained by Fanon:

For the masses, it is the time of continued exclusion, oppression, alienation, and unfreedom. For much of the world's population, living in precarious conditions, the present is stifling. They are the 'living dead' expelled from 'human' society who struggle on a daily basis for dignity and survival. (as cited in Gibson, 2011, p. 4)

As depicted, the struggling life of the colonized has become a normal state of affairs for the colonial subject. However, for nurses that related to their client's suffering were also starting to struggle on a daily basis with their own sense of identity and worth, dignity, and survival. Specifically, some nurses were struggling to maintain their position of superiority in society, as to not to become a part of the 'living dead' conditions. As Fanon claimed "the threat level is always [at a] high alert" (as cited in Gibson, 2011, p. 4). It was starting to become a crisis for nurses to maintain their own sense of identity while trying to treat and manage the diseases of their population. Additionally, the nurses needed to defend themselves from the threat of the 'Other.' As described by Fanon (1986):

The white man is convinced that the Negro is a beast (...) Face to face with this man who is 'different from himself', he needs to defend himself. In other words, to personify the 'Other'. The 'Other' will become the mainstay of his preoccupations and desires. (p. 120)

In this excerpt, Fanon offers that the colonizer can feel threatened by the 'Other' and his/her acts of self-protection are to further personify the 'Other' for its difference.

Drawing again upon Fanon's concept of the 'master' and the 'slave' (Honenberger, 2007), the 'master' does not need to be concerned with the reality of the 'slave' for it is not in his/her consciousness. More simply, the colonizer does not need to be concerned with the plight of the colonial subject. In working with rural Northern and Aboriginal communities, nurses in general were disconcerned with the plight of their clients when it did not affect their work and community living.

As evident from the interviews, the nurses were overwhelmed with the complexity of diseases that their clients had and lacked the skill sets to manage their clients' illnesses

and disease states effectively. The communities were inundated with chronic diseases. Furthermore, the nurses were not able to treat and manage these diseases within the community without additional resources or supports.

During the interviews, some of the nurses described that their roles were to help improve population health outcomes for their clients. This would be more aligned with the values of the *RN Act of 1988* (Government of Saskatchewan, 1988). As such, nursing roles would also include advocating for resources to help to meet their clients' health needs with responsive and relevant care. As seen from the interviews, this attitude was an exception to the rule within colonial relationships. Within a colonial relationship, the majority enforced colonial mentalities by perhaps sustaining the power relations between the 'master' and the 'slave' relationship. However, this does not exclude the oppression that nurses along with their clientele might experience within the colonial systems. Within the rural Northern and Aboriginal communities, the nurses acted upon treating and managing the health of their clients who were ultimately wards of the state and continue to be in trust of the state.

6.1.2 The 'Aboriginal' Construct

The second major finding of this study builds upon the first major finding that the role of the nurses tended to enforce the colonial tenet of treating and managing Aboriginal peoples for illnesses and diseases. In this light, the second major finding included that the nurses were not treating the Aboriginal person for having an illness or disease, but rather they were treating their clients as the illness or disease for being 'Aboriginal'. Withal, Aboriginal peoples were represented by nurses as a 'body of illnesses.' As evident from some interviews, the nurses associated their clients' poor health conditions to the condition of being 'Aboriginal.' These health conditions included addictions and mental health, communicable diseases, and non-communicable diseases. Within these rural Northern and Aboriginal communities, nurses were faced with treating clinical conditions that were complex in care, and often beyond their level of expertise.

From the interviews, participants spoke about being 'ill-prepared' in treating and managing their clients' health conditions. In coping with their inadequacies, the focus of blame shifted from the care providers to the clients. For it was not the fault of the health care provider in not being able to manage their clients' health conditions, but perceived as the fault of the client for being ill. In his book, *Black Skins, White Masks*, Fanon (2008) described this process as 'blaming the victim'. This process of blaming the victim based on one's race has also been referred to as 'racial scapegoating', that is the "projection of blame onto another person or object, who then becomes blameworthy or punishable for something I am in fact guilty for. Scapegoating is a way of avoiding feelings of guilt and responsibility" (Hook, 2004, p. 120). In application, there was an element of 'racial

scapegoating' when the nurses shifted the blame of poor health onto their clients, rather than looking at the issues of population health of Aboriginal peoples from a delivery system perspective.

Within these communities, Aboriginal peoples were starting to believe that it was not their illness that needed to be treated, but themselves. Fanon offered that within this construct the colonial subject has been newly 'pathologized' (as cited in Gibson, 2011). This is a common consequence of colonialism on a colonized population, including Aboriginal peoples in rural, remote, and Northern Canada. For example:

As is typical in all colonial societies, [First Nations] today are characterized as entrenched dependencies in physical, psychological and financial terms, on the very people and institutions that have caused the near erasure of our existence and who have come to dominate us. (Alfred, 2009, p. 42)

This dependency on their colonizer created a sort of reliance on the colonial state for their existence. In this sense, the colonized subject became further subjugated:

When one considers the material consequences of Canada's century-long policy of state-sponsored, forcible assimilation, a simple fact emerges: for generations, opportunities to live well *as an Aboriginal person* have been actively frustrated. Successive governments, committed to the notion that Aboriginal cultures belong only to the past, have made no provision for the well-being of these cultures in the present and future (...) For those who resisted or refused the benefits of assimilation, government policies assured a life of certain indignity. That is the essence of life in the colony: assimilate and be like us or suffer the consequences. (Kirmayer & Valaskakis, 2009, p. xi)

As evident from the literature review in Chapter Two, Aboriginal peoples have endured many hardships related to colonialism that have affected their health as well as their overall living conditions in society. Indigenous health scholars offer that Aboriginal peoples were healthy before they were introduced to the European culture. It was through colonialism, that Aboriginal peoples were introduced to diseases (RCAP, 1996b), and now their disease state is associated with being 'Aboriginal.' For example, as stated by George Wharton James in 1908:

Before the Indian began to use the white man's foods, he was perforce compelled to live on a comparatively simple diet. His choice was limited, his cooking simple. Yet he lived in perfect health and strength (...) and attained a vigour, a robustness, that puts to shame the strength and power of civilized man. (RCAP, 1996a, p. 103)

This above excerpt brings to light examples of Aboriginal peoples being subjugated to the loss of their culture through assimilation of the 'white' man's world. More specifically, this quotation speaks to the notion of self-governance over its population of care, which can be lost within colonial systems. According to Gibson (2010), the identity of the Aboriginal person became constructed as a lived reality of the everyday self. In explanation, Fanon had described that the construct of a colonial identity was created by the subject: "seeing oneself through the eyes of the hostile 'Other'; [and] realization of the first as a constructed reality" (as cited in Gibson, 2011, p. 20). As such, it was difficult for nurses to understand the harsh realities that Aboriginal peoples lived as an everyday existence. Furthermore, it was difficult for Aboriginal peoples to not be affected by the

impact of colonialism, or the colonial process leading toward assault on a population. For example:

Aboriginal peoples in Canada endure ill health, insufficient and unsafe housing, polluted water supplies, inadequate education, poverty and family breakdowns at levels usually associated with improvised developing countries. The persistence of such social conditions in this country (...) [is] an assault on the self-esteem of Aboriginal peoples and a challenge to policy makers. (RCAP, 1996a, p. 1)

The majority of the nurses that worked within these vulnerable communities found it difficult to grasp how Aboriginal peoples can have such dismal and bleak health conditions. In this sense, nurses were becoming horrified by the threatened breakdown of loss of health and life within a population. Drawing upon Kristeva's *Power of Horror: Essay on Abjection* (1982), nurses were abjecting the populations that they cared for. As further described:

The place of the abject is where meaning collapses, the place where I am not. The abject threatens life, it must be radically excluded from the place of the living subject, propelled away from the body and deposited on the other side of an imaginary border which separates the self from that which threatens the self. (Creed, 1993, p. 65)

In caring for Aboriginal peoples within rural Northern communities, nurses were horrified by the poor health of their clients and communities for which they needed to create a separation between themselves and the 'body of illnesses' in order to preserve their own sense of self.

As such, the nurses' experience of repelling their clients' 'body of illnesses' had manifested itself in an exterior space. This space was referred to as 'biology made manifest', in that "it is not possible in practice to think beyond language to an exterior space, but [Kristeva] also acknowledges that moments of creation or upheaval are the product of ruptures in the symbolic crust: *biology made manifest*" (Smith, 1996, p. 34). The nurses' abjection to their clients' 'body of illnesses' was a physical reaction. Their reactions to their clients' deteriorating health conditions may be viewed as beyond any health care measures. For example, some nurses were repelled by their clients' appalling health status through their own 'biology made manifested' reactions. This reaction is similar to one's reaction to 'open wounds, sewage, and even the skin that forms on the surface of warm milk' (Kristeva, 1982). The nurses' abjection to their clients' poor state of health played a role in maintaining a boundary between themselves and their clients. It was a human reaction for the nurses to preserve their own sense of identity and control over their environment.

In making sense of their clients' state of despair, the nurses had a human reaction to the threatened breakdown in meaning caused by the loss of the distinction between the 'subject and object' (Kristeva, 1982). In this research study, nurses experienced challenges in being able to discern between the 'subject' and 'object.' The Aboriginal person's state of existence was being devalued, for Aboriginal peoples were losing their identity through becoming the 'absence of something'. As Kristeva stated:

Loss presents itself to the consciousness as the '*absence of something*.' In this instance, it is the unattainable quality of the particular object that we have once known, or long to know that provides the means to think beyond the particular. (as cited in Smith, 1996, p. 34)

The identity of Aboriginal peoples was being replaced by their state of illnesses or diseases. In the breakdown of the loss of meaning, nurses had difficulty distinguishing between the 'subject' and 'object.' In particular, nurses were not able to make a distinction between their clients being 'ill' and being 'Aboriginal' as the state of illnesses or diseases.

In caring for their clients and populations, nurses' duty to treat illnesses and diseases was replaced by their duty to treat the Aboriginal person for being 'Aboriginal.' For example, in an article by a medical resident in Northern British Columbia, Elliot and de Leeuw (2010) demonstrated that stereotyping an Aboriginal person as a 'drunken Indian' contributed to the misdiagnosis of diabetic ketoacidosis. As seen from this example, the Aboriginal person's identity had become his/her state of illness, wherein being 'Aboriginal' became a representation of treating and managing 'Aboriginal' people as a 'body of illnesses.'

In another example by Elliot and de Leeuw (2010), they offered that health care professionals working with Aboriginal peoples could treat their clients differently based on their representation of race. For example, an elderly Aboriginal woman who was being tested for TB had misinterpreted the seclusion that was ordered for a standard respiratory isolation to mean that she was going to die. The physician interacting with the patient was unaware of the social and historical conditions of TB that had affected Aboriginal peoples. When the patient next met the physician, the latter was surprised how saddened the patient was by the seclusion. The physician was unaware that during her client's lifetime, she had experienced exclusion based on her 'race' due to the segregation she experienced with residential schools. For the health care professional, there was a breakdown of loss of

meaning in treating her patient with TB from her patient being an 'Aboriginal' person with TB. The Aboriginal patient no longer became a patient, but rather became the 'absence of something.' Similarly, in this research study, the participants focused on treating their clients' body as being the source of illnesses and diseases, with 'race' being the focal point for treatment and management of care.

As seen in the first major finding, the Aboriginal person's existence did not stand alone from the existence of the colonial agent, the nurse, for the Aboriginal person's existence was in the consciousness of the state, or in the consciousness of the extension of the state. In the second major finding, the nurses had constructed the identity of the Aboriginal person as a 'body of illnesses', where being 'Aboriginal' became the focal point for nurses to treat illnesses and manage diseases. Through colonial relations between the nurse and client, Aboriginal peoples lost the meaning of their identity and had become an 'absence of something.' The implication to care was that nurses were managing the Aboriginal population as a 'body of illnesses' for the protection of the state and statehood. To follow in the third major finding of this research study, the focus of care was on the nurses' responsibility to protect the state by first 'civilizing', and then 'saving' Native peoples.

6.1.3 Protecting the Segregated State

The third major finding of this study revealed that unbeknownst to most nurses, nursing was being utilized as a means to govern Aboriginal peoples under colonial rulings. In particular, nurses were being used as a means of governmentality in maintaining a division

between the colonial state and the colonized. Specifically, this division was based on the processes of 'Othering' and systemic racism, which led to the nurses' inherent roles of protecting the segregated state from the 'Other.' Within their roles of protecting the segregated state, nurses were managing their clients by treating them as a population, rather than as a people. As stated, in his lectures at the Collège de France from 1977 to 1978 entitled *Security, Territory, Population*, Foucault drew upon a quote from L.P. Abeille to describe:

The people compromise those who conduct themselves in relation to the management of the population, at the level of the population, as if they were not part of the population as a collective 'subject-object', as they put themselves outside of it, and consequently the people are those who, refusing to be the population, disrupt the system. (as cited in Burchell, 2007, p. 43-44)

Emerging from this, nurses as resources of the state were placed in a position to manage the conduct-like of a population, becoming part of the state's force to maintain its logic of civility, discipline, and governance. Foucault defines conduct as:

The activity of conducting (conduire), of conduction (la conduction) if you like, but it is equally the way in which one conducts oneself (se conduit), lets oneself be conducted (se laisse conduire), and finally, in which one behaves (se comporter) under the influence of a conduct as the action of conducting or of conduction (conduction). (as cited in Burchell, 2007, p. xix)

In governing the conduct of a population and the health of a population, nurses were at the forefront of this task as health care providers within rural Northern and Aboriginal communities. Nurses were placed in an opportune position to help govern a population and

its health affairs where they “lived and worked amongst their patients in small remote communities, thus making them ‘effective vehicles’ for promoting modernization principles through preventive and education[al] programs” (McBain, 2006, p. ii).

As seen within this research study, nurses were considered as ‘effective vehicles’ for implementing the mandates of the Ministry of Health within Saskatchewan to govern Aboriginal peoples as a population and not as a person or persons. In essence, the health of the Aboriginal peoples as individuals was not significant for the functioning of the state. As stated by Alfred (2009) on the commentary of the health of (Aboriginal) communities, “conventional approaches to health promotion and community development are not showing strong signs of success” (p. 44). Drawing upon this, sometimes nurses were limited in their resolve to help improve health outcomes of Aboriginal peoples, as they could be constrained by the interest of the state to manage the conduct of its populations.

In continuing upon the work of Abeille within his lecture in January of 1978, Foucault explained that:

Every individual who accepts the laws of his country is in the position of having subscribed to the social contract, accepting and renewing it at every moment by his own behavior, while, on the other hand, the person who violates the laws, breaks the social contract and thereby becomes a foreigner in his own land, consequently falling under the jurisdiction of the penal laws that punish him, exile him, and in a way kill him. (as cited in Burchell, 2007, p. 44)

Within their roles and duties of care, nurses were placed in a position to engage with their population in enforcing them to accept state colonial laws, in which case the population needed to accept a social contract of civility, discipline, and governance with the state.

Indirectly, nurses were governing the population to follow the rules of the state in an effort to 'civilize' the targeted population.

In relation to rural Northern and Aboriginal communities, nurses were managing the conduct of Aboriginal peoples by treating them as a population. From this position, Aboriginal peoples no longer remained a person or people, rather they became a population that needed to be managed under state control. Through this process of destructing the Aboriginal person's identity, nurses were expected to exert their positions of power in an effort to control the conduct of the population, i.e. the possessions of the state.

As revealed from the research findings, nurses were limited within their capacity to provide accessible and equitable health care services to Aboriginal peoples. Furthermore, nurses were situated as agents of governmentality and, as such, were required to secure the state order of their clients' conduct. This was achieved by enforcing the will of the state over Aboriginal peoples through the delivery of health services. The rights of Aboriginal peoples as an Indigenous nation were not recognized by the state or by the colonial agents of the state. Correspondingly, Aboriginal peoples needed to agree to the rules of the state by accepting the social contract as enforced by nurses, in relation to the state. Within rural Northern and Aboriginal communities, the connection between the nurse and the client created an interaction where nurses acted and Aboriginal peoples accepted to be the 'subject-object' acts of civility.

In understanding the roles and challenges of nurses, it was also important to understand how the socio-political and historical impact of colonialism had influenced

contemporary roles within Northern nursing practice. Since the 1930s, the direction of nursing care within these communities was to “become direct and primary-care givers to Aboriginal communities as the main representative of a state-directed health care system” (Drees & McBain, 2001, p. 51). Almost a century later, nursing care within these communities was still deployed as provisions of care that were under state direction. Within this research study, nursing roles were influenced and shaped by the state, thus nurses were its representatives in delivery of health services as to meet the needs of the state.

In particular, nurses played a role as a collective force in protecting the segregated state from the social losses associated with being an ‘Aboriginal’ person. This social loss was an impact of colonialism on the identity of a culture and a nation. As further explained, the impact of colonialism on Aboriginal peoples contained:

A colonial process of ‘civilizing’ Indigenous people, making us into citizens of the conquering states, so that instead of fighting for our lands, and resisting further colonization, we seek a *resolution* that is acceptable to and non-disruptive for the state and society we have come to embrace and identify with. (Alfred, 2009, p. 51)

The social demoralization and alienation of Aboriginal peoples was part of the colonial process, and extended back to the 17th century (RCAP, 1996b). A part of this process was land dispossession and containment on reserves; for instance, “reserves were not new. They had been a feature of relations between the French and their Indians allies, and the process of creating them was carried over by the British [Empire]” (RCAP, 1996b, p. 265).

Canada has had a long standing history of colonialism with Aboriginal peoples dating back to the 17th century with the French missionaries, followed by the British

Empire in the 18th century to current practices (RCAP, 1996b). These historic-political discourses of ‘civilizing’ Native peoples as depicted within legislation had an impact on present day nursing practices, wherein the process of ‘civilizing’ Native peoples was part of nurses’ roles in protecting the segregated state from immoral contact with Aboriginal peoples.

Additionally, the goal of the missionaries and the British Empire was related to the goal of ‘civilizing the Indians’, where “missionaries and humanitarians [that were] appalled at the deterioration in living conditions in areas where settlements were devastating traditional Aboriginal cultures and economies, called for action to ‘save’ them” [emphasis added] (RCAP, 1996b, p. 265).

When the British Empire took majority control of Canada, the *Gradual Civilization Act* of 1857 was implemented, thus contributing to Canada’s timeline of colonial events (Castellano, Archibald, & DeGagné, 2008). This Bill sanctioned by Queen Victoria and Governor General Sir Edmund Walker Head was passed by the Fifth Parliament of the Province of Canada (1857). In this act, it stated that it was:

Desirable to encourage the progress of civilization among the Indian Tribes in this Province, and the gradual removal of all legal distinctions between them and Her Majesty’s other Canadian Subjects, and to facilitate the acquisition of property and of the rights accompanying it. (Fifth Parliament of Canada, 1857, p. 84)

Furthermore, the Parliament of the United Kingdom (1865) passed the *Colonial Laws Validity Act 1865*, an act to (officially) remove doubts as to the validity of colonial laws. The purpose of this Act was to remove any apparent inconsistency between local

'colonial' and British 'imperial' legislation. This act was applied in authorizing the "passing or to ascent to Laws for Peace, Order, and good Government of such Colony" (Parliament of the United Kingdom, 1865, p. 566). This act was used in strengthening the position of colonial legislatures and affirming their subordination to the Westminster Parliament, one of the houses of the Parliament of the United Kingdom. The law was used to help alleviate doubts related to the validity of colonial laws including its possessions in Canada. This helped to create regulations originating from colonial laws to shape national governance over its current possessions including Aboriginal peoples.

In application to Northern nursing practice, nurses were unaware of the historical impact that colonialism had on Aboriginal peoples and their population-based health indicators. Without knowing, nurses were engaged in historical practices of 'civilizing' Native peoples through their current duties and practices. Specifically, nurses were uninformed that their roles and responsibilities as health care providers were shaped by socio-political and historical contexts related to colonialism. Unwittingly, nurses were active in the assent to colonial laws governing colonial subjects. In maintaining 'peace, order, and good government', nurses were shaped by colonial influences to act as agents of governmentality, as well as instruments of colonial legislations.

Moreover, nurses were exercising their power to control the conduct of Aboriginal peoples for the functionality of the state. In Foucault's lectures at the Collège de France (1975-1976) entitled *Society Must be Defended*, he made reference to the "representation of power and with the actual functioning of power" (2003, p. xvii). Within their nursing roles of 'civilizing' Native peoples, nurses were not necessarily the representation of power;

instead, they were the actual functioning of power. Quintessentially, nurses were used as means of governmentality to civilize 'Native' people in order to maintain normalcy and functioning of the state. To further elaborate, Foucault (2003) offered that "putting forward a truth [could] function as a weapon" (p. xxi). Unbeknownst to the nurses, they were being 'put forward' as a functioning 'weapon' in an effort to isolate 'Native' people from the state and the rest of the state's subjects. As such, nurses would be considered as a 'weapon', in specific to the "discourse of race war or race struggle" (Foucault, 2003, p. 65). Foucault makes the distinction that the struggles of the people are not rooted in a racist discourse; rather, the effort is localized in the discourse of 'race war' or 'race struggle'. As situated in the discourse of a 'race war' or 'race struggle', nurses functioned as a weapon to 'civilize' and 'save' Aboriginal peoples for purposes of the state and statehood.

Mainly, the role of protecting the segregated state was being conducted through their nursing roles of 'civilizing' Native peoples. Additionally, although not a primary role, nurses were also participating in missionary work of 'saving' Native peoples. However, the work of 'civilizing' Native peoples was a forefront responsibility within the state followed by responsibilities to the mission. As Foucault remarked, "if the 'government of men' is understood as an activity that undertakes to conduct individuals, 'pastoral power' concentrates this activity in the regime of religious institutions, while governmentality locates it in the direction of political institutions" (as cited in Burchell, 2007, p. xix). In addition, Foucault offered that from the end of the 17th and the beginning of the 18th century, there was a shift of conducting people from 'pastor power' to more 'political

institutions' (Burchell, 2007). Although there was an element of 'saving' Native peoples, this was not an overt direction from the state.

With a shift in religious orders to political institutions, nurses' primary duty of care was based in 'civilizing' Native peoples followed by offering 'Native' people an opportunity for salvation. The focus became less directed towards fulfilling missionary obligations, but more on state-directed duties to control the conduct of its population, where 'saving' Native peoples was a secondary goal to 'civilizing' Native peoples as dictated by the state. However, there was still a degree of nurses wanting to improve Aboriginal peoples' health through redemption of the soul. For instance, in contemporary nursing roles within isolated Northern Canadian Aboriginal communities, nurses were not necessarily concerned with 'saving' the soul of an unborn 'Native' child to-be, but rather 'civilizing' the child born into society as a 'civilized' body.

In summary, nurses acted as representatives of the state in managing a population that needed to be predominately 'civilized'. The main challenge for nurses in working within rural Northern and Aboriginal communities was that they were unaware of the roles that were enforced upon them by the state. Therefore, it is imperative for nurses to be aware of their roles in delivering health services to Aboriginal peoples, not for purposes of state order, but for the decency of the people within the state.

6.2 Implications

The findings of this research study indicated that nurses must have a better understanding of the impact of colonialism on Aboriginal peoples' health before they engage with local communities. Knowledge development through postcolonial scholarship can help strengthen nurses' identity and roles as health care providers in working with marginalized populations. The findings of this research study can further serve as the foundational knowledge in guiding clinical practice, primary health care, research, and education. One of the standard practices that might be challenged through future directions would include strengthening health services delivery toward the needs of the clients and families within rural Northern and Aboriginal communities, rather than practices being service-based.

6.2.1 Practice

First, the findings presented in this dissertation demonstrated the importance of self-reflexivity for nurses who practiced in Northern Canada. In these locales, nursing practice is shaped by the land, the history, and the diversity of the communities, therefore reflection must occur prior to engaging with these communities. Postcolonial theory requires that cultural, political, and socio-historical contexts be analyzed to reveal how nurse-client relations are structured and health inequities are maintained. Nurses must critically examine their own positionality, as well as the culture of their nursing practice and how these may reinforce norms, racism, power dynamics, social control, and health inequities.

Furthermore, the findings of this study reverberate a lack of inclusivity, on the nurses' part, in considering their clients' sense of self and community, right of choice, and

system of thought regarding health and healing. Nurses in the study were limited in recognizing the values, priorities, and capacities of the rural Northern and Aboriginal communities they served. Nurses should reach out to their communities and collaborate with patients, families, and Band members. By doing so, nurses would be better situated in appreciating one another's roles and in understanding and responding to the cultural, socio-political, and economic needs of the community. In turn, nurses could apply this wisdom in treatment planning and program sustainability. In addition, nurses should co-create a definition of health with their communities to foster community engagement and empowerment, as well as mutually integrate traditional practices with modern medicine in a culturally safe manner, thus resulting in an exchange of knowledge, skills, and power.

Within this setting, nurses would benefit from advanced nursing practice for working with complex health conditions. For example, specialization in advanced nursing practice can help strengthen the nurse-client relationship, as well as help nurses to provide responsive and relevant health care within these communities. Without advanced nursing practice, it would be difficult for nurses to provide meaningful care to their communities and to be professionally responsible and competent within their current scope of practice.

Additionally, the research findings of this study presented the need to deconstruct narrow views of being 'Aboriginal' and to help eliminate marginalizing practices in health care through culturally safe policy reform. From the outset, colonialism must be recognized as a primary determinant of health, influencing health outcomes and collective well-being. National Aboriginal health policy must be flexible in recognizing the diversity of needs, resources, and cultures of Aboriginal populations, and must be built on Aboriginal concepts

of healing, such as that of cultural identity, community, and commitment. To this effect, the system must be adaptive to traditional values and accommodative to socio-cultural community needs.

Furthermore, national objectives must be established, placing social determinants of health at the forefront of the agenda, as with other priorities such as women's health, child welfare, and community health. Due process towards health equity further requires a concerted effort among federal, provincial and territorial governments, regional jurisdictions, and Northern Canadian Aboriginal communities to share accountabilities and reduce financial constraints, thereby facilitating self-governance and health services delivery. The study findings also indicate, beyond funding and resources, that leadership at all levels is required. In addition, goals would include confronting oppressive practices, developing and implementing culturally responsive programs and care models, sharing success stories, and advocating for social justice and equitable access to care. Additionally, integrating services amongst primary health care teams and health regions can contribute to strengthening knowledge and expertise, ultimately helping to improve the quality and delivery of health care services for Aboriginal peoples in Northern Canada.

6.2.2 Research

The findings presented in this dissertation offered that nurses would benefit from knowledge into Aboriginal peoples' views of health and traditions. Community-based research and action focusing on collective strengths is a first step towards inclusive, meaningful interchanges. Specifically, community-based research would facilitate the self-identification of problems and solutions, thus lending critical insights into issues such as health, poverty, living conditions, and housing. The study being qualitative further provided an illustrative context into day-to-day nurse-client encounters, thus depicting the colonial processes shaping contemporary realities. More critical population health approaches are also needed to reveal the linkages surrounding health, health equity, and social determinants of health. Research must too examine the impact of upstream processes on vulnerable populations, namely Aboriginal youth, women, and Elders.

In addition, greater surveillance data and registries, particularly of non-status First Nations, Métis, and urban Aboriginals, necessitate in developing public policy reflective of the health needs and realities of all Aboriginal peoples. In general, the application to research from rural Northern and Aboriginal communities can be applied to other Aboriginal communities that can benefit from greater solidarity and processes of cohesion. In particular, community inclusivity can also be applied to other communities to help support clients, families, and communities to be involved in decision making processes about priorities for health actions.

6.2.3 Education

Undergraduate nursing students must be prepared to help meet cultural safety competencies upon entry-to-practice, which can also be conceived as part of ongoing professional development. This requires the incorporation of Aboriginal health concepts, values, and life ways into nursing curricula to fully appreciate the historical and socio-political realities affecting Aboriginal populations as they strive towards self-governance. In addition, processes of 'Othering' and systemic racism that contribute to marginalized practice must further be examined to prevent and eliminate their occurrences. Academic institutions must too work in partnership with communities to evaluate the cultural appropriateness of population-specific content within the delivery of Northern health services to Aboriginal peoples.

Moreover, inter-professional collaboration can be a uniting front in providing culturally safe care, and medicine and nursing faculties must partner together to develop core competencies for First Nations, Métis and Inuit health in rural, remote, and Northern communities. A framework for specialty practices that defines the roles and responsibilities of nurses working in rural Northern settings is one project underway in Saskatchewan (Fitz-Gerald, 2013). Given the shift towards health promotion and illness prevention, integrated training amongst disciplines may further serve to reduce the divide between public health and primary care services. At the practice level, providing mentorship opportunities for students and new hires with nurses or paraprofessionals is another way of integrating oneself and one's practice into the community, thereby facilitating respect, support for, and an understanding of providing care to societal-shunned populations.

In summary, the findings indicated that, through a cohesive approach to clinical practice, primary health care, research, and education, social and systemic transformation is possible in improving health outcomes and reducing health disparities. Programs and services, training, and health services policy must also be culturally safe, inclusive, and accessible. These must also incorporate actions to improve social determinants of health, thus effecting social change and justice to sustain the health and well-being of Aboriginal peoples in Northern Canada.

6.3 Limitations

There were several limitations to be mindful of that can potentially impact the credibility, dependability, and overall trustworthiness of the results. The limitations of the study offered were related to Critical Discourse Analysis (CDA). Credibility, which refers to confidence in the truth of the data and interpretation of the data (Polit & Beck, 2008), is one limitation of CDA. While CDA has been recognized as a qualitative research method (Denzin & Lincoln, 2000), there are concerns that CDA does not necessarily understand an individual's subjective experience. Rather, through interpretation of text, individuals or groups construct particular understanding of texts (Crowe, 2005). Another main criticism of CDA is that researchers may have biases within their research study. For example, researchers can read what they want from the text they are analyzing (Schegloff, 1997). Researcher bias can affect the credibility and trustworthiness of a study if not addressed and acknowledged. CDA can be a reliable method if researchers acknowledge their biases,

which can be minimized through the use of a consistent methodological approach (Chouliaraki & Fairclough, 1999; Smith, 2007).

Another methodological limitation of CDA is that there can be various interpretations to discourse analysis through the interpretative process of language, where results may not be generalized to other situations (Crowe, 2005). Specifically, an individual's experience can be directly represented in language, and particular interpretations within discourse analysis may not be readily transferred to other situations. This limitation of transferability may impact the trustworthiness of the results. Transferability is defined as the generalizability of the data where findings can be applicable to other settings or groups (Polit & Beck, 2008). This particular concern also calls for researchers to be transparent on the decisions they make; as well as, be aware of how that may impact the overall trustworthiness of the study. In ensuring consistency within the research study, all interviews were conducted by the Principal Investigator using the same semi-guided interview sheet for each interview. Data analysis was also conducted solely by the Principal Investigator. The Principal Investigator was aware of the limitations of CDA, and was careful not to generalize the findings of the study. Limitations were minimized by interviewing participants from a random pool of employees that volunteered to be on the study; in helping to gain a wide collective pool of experiences.

Researchers need to be mindful of the decisions they make and show reflexivity within their method to back the trustworthiness of their findings (Polit & Beck, 2008). Ultimately, within the use of CDA, researchers need to be aware of their own values and beliefs and how these might influence their results. Acknowledging researcher assumptions

through reflexivity can help add transparency to the research study in assuring overall trustworthiness. Keeping in mind of the limitations, in contexts where power dominance is a factor, CDA serves useful in understanding the power-based subject of study. Within this research study, the limitations were acknowledged and addressed through reflexivity, as well as consulting with community stakeholders about their local health needs. This last step helped to ensure that the voice of the communities were considered in helping to address the communities' health needs with meaningful and relevant care.

Conclusion

History will have to record that the greatest tragedy of this period of social transition was not the strident clamor of the bad people, but the appalling silence of the good people.

- Martin Luther King, Junior

A critical examination of health inequities within rural and remote Northern Canadian Aboriginal communities calls upon the exploration of how colonial mentalities have been rooted in the cause of current state health affairs and poor social determinants of health among Aboriginal peoples (Czyzewski, 2011). Colonial legislation and colonial relations can also be contributing factors to the current health gaps among Aboriginal populations, specific to the negative representation of Aboriginal peoples in society. Moreover, exploring present day history within isolated Northern Canadian Aboriginal communities cannot be examined without the backdrop of colonization and racism (LaRocque, 2010).

Although this qualitative research study addressed difficult social issues such as the racialization of Aboriginal peoples through 'Othering', the exploration of health inequities related to its various socio-political and historical contexts was not intended to be romanticised or dramatized. The caution lies in that conducting research that seeks positives can tend to 'avoid the negative' that exists within socialized issues (LaRocque, 2010). The aim of this research inquiry was to provide a critical examination that spoke to humanity and justice of a vulnerable population where a postcolonial approach can help develop knowledge based in critical research and scholarship in nursing.

For the benefits of integrating theory and research with practice can help nurses to address health inequities framed within colonial relationships, and its present day impact on health and health services for marginalized communities. In addressing social injustices and health inequities, nurses must consider how social and historical conditions such as colonization can affect the health system and the health of populations. Nursing's social mandate for health requires nurses to be skilled in navigating political and historical contexts to provide equitable health services for vulnerable populations and marginalized communities.

In particular, across the Canadian health care landscape, social health issues for Aboriginal peoples are well documented within current literature and federal health reports. Yet, leading Indigenous scholars pronounce that the levels of health inequities among Aboriginal peoples are pressing matters that have been ignored for far too long. In general, being complacent about normative health statuses can be considered as a social injustice and travesty for Aboriginal peoples. As local and national concerns for health inequities among Aboriginal peoples are becoming more prevalent in everyday discourses, there is growing attention on the need to address these grave matters surrounding Aboriginal peoples' health. The state of health affairs regarding Aboriginal peoples, particularly within First Nations and Métis in rural and remote Northern communities, is gaining national and global interest.

Through a critical analytical approach, the status quo of Aboriginal peoples' health was examined to gain a better understanding of how socio-political and historical impacts of colonialism played a part in daily discursive practices. Within these communities, the status

quo of ill-health among Aboriginal peoples was maintained in order to help protect the segregated state between the colonizer and the colonized. Drawing upon this, nurses played a role in maintaining the status quo of ill-health among Aboriginal peoples within these vulnerable communities. In this doctoral dissertation focusing on *Nursing the 'Other'* through a critical theoretical perspective, knowledge was brought forward about what it was like for nurses to work within isolated Northern Canadian communities. Specifically, postcolonial theory was deployed in gaining a better understanding of nurses' roles and challenges in delivering Northern health services and in meeting the communities' health and cultural needs with responsive and relevant care.

Primarily, the objectives of this qualitative research study included exploring what are the roles and challenges of nurses working within rural Northern and Aboriginal communities, and what resources can help support or impede nurses' work in providing health care services to their clients and communities. Aptly applied, theorists including the works of: Frantz Fanon, Julia Kristeva, and Michel Foucault provided a theoretical framework to inform the research study about nurses working with marginalized populations.

Semi-structured interviews were conducted with twenty-five participants including frontline nurses, physicians, and regional health care administrators working within rural and remote Northern communities in Saskatchewan. Participants described their experiences and knowledge of providing health care services to community residents within rural and remote settings. The interviews were analyzed through Critical Discourse Analysis

in helping to better understand how discursive practices were shaped by socio-political and historical contexts as presented within language.

During the data analysis, four main themes were revealed within the study. These themes included *Structural Health care Systems*, *Public Portrayal of 'Native' People and 'Native' Communities*, *Colonizing Nursing Practice*, and *Mobilizing Pathways in Aboriginal Health*. Nursing practice within rural Northern and Aboriginal communities was relational-based between nurses and clients within the context of a colonial-based health care system. As the evidence revealed, there were three emergent and central findings evolving from this research study. They include (I) *the Colonial Nurse-client Relationship*; (II) *the 'Aboriginal' Construct*; and (III) *Protecting the Segregated State*. In particular, the meaning for each major finding is as follows:

1. The Aboriginal person did not exist without being in a relation with their colonial agent, the nurse; (Major Finding One)
2. As such, the Aboriginal person's structure of his/her self became the 'absence of something' within the health care system; (Major Finding One)
3. With a loss of meaning, being 'Aboriginal' was constructed as a source of treating illnesses and managing diseases; (Major Finding Two)
4. As a collective force, nursing was used as a means to govern Aboriginal peoples, with provisions of care situated within colonial laws; (Major Finding Three)
5. For purposes of the state, nurses were primarily participating in civility acts; followed by missionary work to control the conduct of its entrusted-state population. (Major Finding Three)

In summary, these findings had similarities with each other and were interlinked with one another. Simply stated, the connection was rooted in the delivery of Northern health services based in a colonial-derived health care system. These findings revealed that nurses were unsuspecting of their roles as frontline health care providers in managing a population, which was to 'civilize' and 'save' a population that would be worthy of value within the dominant society.

With a shift in religious traditions to political institutions, the social health mandate embedded within the dominant society changed from 'saving' Native peoples to 'civilizing' Native peoples. For nurses, their primary functioning role as agents of governmentality was to 'civilize' Native peoples then to offer an opportunity for salvation. Consequently, it was difficult for nurses to work within a complex environment where they were not aware of the socio-historical and political impacts of colonialism on Aboriginal peoples' health within these vulnerable communities. However, knowledge development through postcolonial scholarship can help nurses to be self-reflective of their motivations, values, and judgements in reflecting upon their duties and responsibilities as health care providers.

Notably, self-reflective practice can lend itself for nurses to be aware of the impact that the power of their self has on the 'Other', as well as understand the impact that the 'Other' has in shaping their individualized self as nurses. Furthermore, identifying resources and supports can help nurses to achieve their learning goals with evaluative measures. An integral part of nursing practice was for nurses to feel like they were being supported within their work, endeavouring to be proud of their work. Integrating developments in clinical,

research, and education can assist nurses in hopeful dialectic action to help meet Aboriginal peoples' health and cultural needs with dignified and respectful care.

Broadly applied, critical discourse about Aboriginal peoples' health within isolated Northern Canadian communities can help nurses to de-signify the meaning behind the shame and silence for those alike to the forefront of society.

References

- Aboriginal Affairs and Northern Development Canada. (2013, January). *Aboriginal demographics and well-being*. Retrieved from <http://www.aadnc-aandc.gc.ca/eng/1358878601807/1358878656346>
- Aboriginal Nurses Association of Canada. (n.d.). *Fact sheet*. Retrieved from <http://www.anac.on.ca/Documents/Nursing%20Fact%20Sheet%20Final.pdf>
- Adelson, N. (2005, March/April). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96(Suppl. 2), S45-S61.
- Alfred, G. T. (2009, November). Colonialism and state dependency. *Journal of Aboriginal Health*, 42-60. Retrieved from http://www.naho.ca/jah/english/jah05_02/V5_I2_Colonialism_02.pdf
- Anderson, J. (2000). Gender, 'race', poverty, health, and discourses of health reform in the context of globalization: A post-colonial feminist perspective in policy research. *Nursing Inquiry*, 7(4), 220-229.
- Anderson, J., & McCann, K. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher*, 9(3), 7-27.
- Anderson, J. (2004). The conundrums of binary categories: Critical inquiry through the lens of postcolonial feminist humanism. *Canadian Journal of Nursing Research*, 36(4), 11-16.

- Anderson, J. (2009). Looking back, looking forward: Conceptual and methodological trends in nursing research in Canada over the past decade. *Canadian Journal of Nursing Research, 4*(1), 47-55.
- Anderson, J. M., Kirkham, S. R., Browne, A. J., & Lynam, M. J. (2007). Continuing the dialogue: Postcolonial feminist scholarship and Bourdieu – discourses of culture and points of connection. *Nursing Inquiry, 14*, 178-188.
- Ashcroft, B., Griffiths, G., & Tiffin, H. (2000). *Post-colonial studies: The key concepts*. London, England: Routledge.
- Ashton, C. W., & Duffie, D. (2011). Chronic kidney disease in Canada's First Nations: Results of an effective cross-cultural collaboration. *Healthcare Quarterly, 14*(3), 42-47.
- Assembly of First Nations. (2005). *First Nations action plan on continuing care*. Ottawa, Canada: Author.
- Assembly of Manitoba Chiefs, General Chiefs Assembly, Opaskwayak Cree Nation. (2011, January). *Certified copies of adopted resolutions*. Retrieved from http://www.fncaringsociety.com/sites/default/files/Assembly-Manitoba-Chiefs-Certified_Resolutions_Jan2011.pdf
- Banerjee, S., & Tedmanson, D. (2010). Grass burning under our feet: Indigenous enterprise development in a political economy of whiteness. *Management Learning, 41*(2), 147-165
- Bartlett, J. G. (2003, May/June). Involuntary cultural change, stress phenomenon and Aboriginal health status. *Canadian Journal of Public Health, 94*(3), 165-166.
- Bhabha, H. (1994). *The location of culture*. London, England: Routledge.

- Bohaker, H., & Iacovetta, F. (2009). Making Aboriginal peoples' immigrants too': A comparison of citizenship programs for newcomers and Indigenous peoples in postwar Canada, 1940s–1960s. *The Canadian Historical Review*, 90(3), 427-461
- Boyer, Y. (2004). *First Nations, Métis, and Inuit health care: The Crown's fiduciary obligation*. Ottawa, Canada: National Aboriginal Health Organization.
- Brookes, D. (2007, February). Understanding the value of qualitative research in nursing. *Nursing Times*, 103(8), 32-3.
- Browne, A. J. (2005). Discourses influencing nurses' perceptions of First Nations patients. *Canadian Journal of Nursing Research*, 37(4), 62-87.
- Browne, A. J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science and Medicine*, 64(11), 2165-2176.
- Browne, A. J., Smye, V. L., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *Canadian Journal of Nursing Research*, 37(4), 16-37.
- Browne, A. J., & Varcoe, C. (2006, September). Critical cultural perspectives and health care involving Aboriginal peoples. *Contemporary Nurse*, 22(2), 155-167.
- Burchell, G. (Trans.). (2007). *Michel Foucault: Security, territory, population*. New York, NY: Picador.
- Bushy, A. (2002). International perspectives on rural nursing: Australia, Canada, USA. *Australian Journal of Rural Health*, 10, 104-111.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing* 13(3), 181-184.

Canadian Association for Rural & Remote Nursing. (2008, January). *Rural and remote nursing practice parameters: Discussion document*. Retrieved from <http://www.carrn.com/files/NursingPracticeParameters.pdf>

Canadian Broadcasting Corporation. (2008, August 28). 'Social injustice is killing people on a grand scale': Report. Retrieved from <http://www.cbc.ca/news/health/story/2008/08/27/who-socdet.html>

Canadian Institutes of Health Research. (2007). CIHR guidelines for health research involving Aboriginal peoples. Ottawa, Canada: Author. Retrieved from <http://www.cihr-irsc.gc.ca/e/29134.html>

Canadian Institutes of Health Research, National Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2010, December). *Tri-council policy statement: Ethical conduct for research involving humans*. Ottawa, Canada: Author.

Canadian Nurses Association. (2003). *The values of nursing in the community*. Ottawa, Canada: Author.

Canadian Nurses Association. (2005, October). *Chronic disease and nursing: A summary of the issues* (BG 003). Ottawa, Canada: Author.

Canadian Nurses Association. (2009, November). *Determinants of health* (PS-109). Ottawa, Canada: Author.

Canadian Nurses Association. (2013a). *Better health: Primary health care*. Retrieved from <http://www.cna-aiic.ca/en/>

Canadian Nurses Association. (2013b). *Primary health care: PHC Conceptual Model*. Retrieved from <http://www.cna-aiic.ca/en/>

Canadian Population Health Initiative. (2004). *Improving the health of Canadians*. Ottawa: Author.

Canadian Primary Health Care Research & Innovation Network. (2011). *The definition of primary health care*. Retrieved from http://www.cphcrin-rcrissp.ca/index.php?option=com_content&view=article&id=59:banner-3&catid=12:news&Itemid=6

Canadian Public Health Association. (2011, Autumn). Frontline health: Beyond health care. *CPHA Health Digest*, 35(3). Retrieved from <http://www.cpha.ca/en/about/digest/xxxv-3/xxxv-3-49.aspx>

Canales, M. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science*, 22(4), 16-31.

Carter, J., & Hollinsworth, D. (2009). Segregation and protectionism: Institutionalised views of Aboriginal rurality. *Journal of Rural Studies*, 25(4), 414-424.

Castellano, M. B. (2004). Ethics of Aboriginal research. *Journal of Aboriginal Health*, 98-114.

Castellano, M. B., Archibald, L., & DeGagné, M. (Eds.). (2008). *From truth to reconciliation: Transforming the legacy of residential schools*. Ottawa, Canada: Aboriginal Healing Foundation.

- Central East Local Health Integration Networks. (2010, April). *Chronic kidney disease initiatives promising practice report*. Retrieved from <http://www.centraleastlhin.on.ca>
- Chan, M. (2008, May). Primary health care starts with people. Symposium conducted at the meeting of the International Federation of Red Cross and Red Crescent Societies Global Health and Care Forum 2008, Geneva, Switzerland. Retrieved from <http://www.who.int/dg/speeches/2008/20080514/en/index.html>
- Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research*, 14, 1140–1150.
- Chew, A., & Greer, S. (1997). "Contrasting world views on accounting," *Accounting, Auditing & Accountability Journal*, 10(3), 276-298
- Chinn, P.L., & Kramer, M. K. (1999). *Theory and Nursing: Integrated Knowledge Development*. St. Louis, MO: Mosby.
- Chouliaraki, L. & Fairclough, N. (1999). *Discourse in late modernity: Rethinking critical discourse analysis*. Edinburgh, Scotland: Edinburgh UP.
- Cornelius, J. J. (1976). *Friend and foe: Aspects of French-American cultural contact in the sixteenth and seventeenth centuries*. Toronto, Canada: McClelland & Stewart.
- Coyte, P. & Holmes, D. (2006). Beyond the art of governmentality: Unmasking the distributional consequences of health policies. *Nursing Inquiry*, 13(2), 154-160.
- Creed, B. (1993). Horror and the monstrous feminine: An imaginary abjection. *Screen*, 27(1), 44-71. doi:10.1093/screen/27.1.44

Crowe, M. (2005). Discourse analysis: Towards an understanding of its place in nursing.

Journal of Advanced Nursing, 51, 55–63.

Czyzewski, K. (2011). Colonialism as a Broader Social Detriment of Health. *The International*

Indigenous Policy Journal, 2(1), Article 5.

Dagnone, T. (2009). *Saskatchewan Health: Patient First Commissioner's Report*. Retrieved

from <http://www.health.gov.sk.ca/patient-first-review>

de Beauvoir, S. (1992). *The force of circumstance, Vol. II: The autobiography of Simone de*

Beauvoir (Peter Green, Trans.). New York, NY: Paragon House.

Denzin, N., & Lincoln, Y. (2000). *Handbook of Qualitative Research* (2nd ed.). London,

England: Sage.

Drees, L. M., & McBain, L. (2001). Nursing and Native peoples in Northern Saskatchewan:

1930s-1950s. *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine*, 18, 43-65.

Ekstrom, D. N., & Sigurdsson, H. O. (2002). An international collaboration in nursing

education viewed through the lens of critical social theory. *Journal of Nursing Education*, 41(7), 289-294.

Elliot, C. T., & de Leeuw, S. N. (2010). Our Aboriginal relations: When family doctors and

Aboriginal patients meet. *Canadian Journal of Optometry*, 72(4), 26-28.

Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New

Zealand's Maori population. *American Journal of Public Health*, 96(4), 612-617.

Fairclough, N. (1992). *Discourse and Social Change*. Cambridge, England: Polity Press.

Fairclough, N. (1995). *Critical Discourse Analysis*. London, England: Longman.

- Fairclough, N. (2001). *Language and Power*. London, England: Longman.
- Fairman, J., Rowe, J., Hassmiller, S., & Shalala, D. (2011). Broadening the scope of nursing practice. *The New England Journal of Medicine*, 364(3), 193-6. doi:10.1056/NEJMp1012121
- Falk-Rafael, A., & Coffey, S. (2005). Financing, policy, and politics of health care delivery. In L. Yiu and C. L. Stamler (Eds.), *Community health nursing: A Canadian perspective*. Toronto, Canada: Pearson Education.
- Fanon, F. (1986). *Black skin, white masks* (C. L. Markmann, Trans.). London, England: Pluto Press. (Original work published 1963)
- Fanon, F. (2004). *The wretched of the earth* (R. Philcox, Trans.). New York, NY: Grove Press. (Original work published 1963)
- Fanon, F. (2008). *Black skin, white masks* (R. Philcox, Trans.). New York, NY: Grove Press. (Original work published 1952)
- Federal-Provincial Exploratory Meeting. (2010, February). *Record of decision: Jordan's principle*. Retrieved from <http://www.fncaringsociety.com/sites/default/files/JP-Document-from-Pictou-Case.pdf>
- Fifth Parliament of Canada. (1857). *Statutes of the Province of Canada*. Toronto, Canada: S. Derbishire & G. Desbarats.
- First Nations Information Governance Centre. (2011). First Nations regional health survey (RHS): Best practice tools for OCAP compliant research. Ottawa, Canada: Author.
- Fitz-Gerald, B. (2013, Summer). Optimizing the scope of the RN: An update on RN specialty practices. *SRNA NewsBulletin*, 15(3), 13.

- Foster, C. H. (2006, April). What nurses should know when working in Aboriginal communities. *The Canadian Nurse*, 102(4), 28-31.
- Foucault, M. (2003). *Society must be defended* (D. Macey, Trans.). New York, NY: Picador.
- Foucault, M. (1980). *Power/ Knowledge* (C. Gordon, Trans.). New York, NY: Pantheon Books.
- Foucault, M. (1990). *The history of sexuality: An introduction*. New York, NY: Vintage Books.
- Foucault, M. (1995). *Discipline and Punish*. New York, NY: Random House.
- Garner, R., Carrière, G., & Sanmartin, C. (2010, June). *The health of First Nations living off-reserve, Inuit, and Métis adults in Canada: The impact of socio-economic status on inequalities in health* (no. 82-622-X – No. 004). Ottawa, Canada: Statistics Canada.
- Gastaldo, D., & Holmes, D. (1999). Foucault and nursing: A history of the present. *Nursing Inquiry*, 6, 231-240.
- Gerlach, A. J. (2012, June). A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy*, 79(3), 151-158. doi:10.2182/cjot.2012.79.3.4
- Gibson, N. C. (Ed.). (2011). *Living Fanon: Global perspectives*. New York, NY: Palgrave Macmillan.
- Government of Canada, Department of Justice. (1982). *Constitution Act, 1982, Canadian Charter of Rights and Freedoms*. Retrieved from <http://laws-lois.justice.gc.ca/eng/const/page-15.html>
- Government of Saskatchewan. (1988). *The registered nurses Act*. Regina, Canada: The Queen's Printer.

- Green, B. L. (2010). Culture is treatment: Considering pedagogy in the care of Aboriginal peoples. *Journal of Psychosocial Nursing*, 48(7), 27-34. doi:10.3928/02793695-20100504-04
- Greer, S., & Patel, C. (2000). The issue of Australian Indigenous world-views and accounting. *Accounting, Auditing & Accountability Journal*, 13(3), 307-329.
- Gregory, D. (1992). Nursing Practice in Native communities. In A. J. Baumgart & J. Larsen (Eds.), *Canadian Nursing Faces the Future* (pp. 163-176). Toronto, Canada: Mosby.
- Gregory, D. (2005). Aboriginal health and nursing research: Postcolonial theoretical perspectives [Editorial]. *Canadian Journal of Nursing Research*, 37(4), 11-15.
- Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N.K. Denzin & Y.S. Lincoln (eds.), *Handbook of qualitative research* (pp.105-117). Thousand Oaks, CA: Sage.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In: N.K. Denzin & Y.S. Lincoln (3rd ed.), *The Sage handbook of qualitative research* (pp. 163-188). Thousand Oaks, CA: Sage.
- Hamilton, W. B. (1978). *The Macmillan book of Canadian place names*. Toronto, Canada: Macmillan.
- Harris, S. B., Naqshbandi, M., Bhattacharyya, O., Hanley, A. J. G., Esler, J. G., & Zinman, B. (2011). Major gaps in diabetes clinical care among Canada's First Nations: Results on the CIRCLE study. *Diabetes Research and Clinical Practice*, 92, 272-279. doi:10.1016/j.diabres.2011.02.006

- Harrison, R. (2002). Archaeology and the colonial encounter. *Journal of Social Archaeology*, 2(3), 352-377.
- Hay, D., Varga-Toth, J., & Hines, E. (2006, September). *Frontline health care in Canada: Innovations in delivering services to vulnerable populations*. Ottawa, Canada: Canadian Policy Research Networks.
- Health Canada, First Nations & Inuit Health. (2005, January). *First Nations comparable health indicators*. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/2005-01_health-sante_indicat-eng.php
- Health Council of Canada. (2013). *Progress report 2013: Health care renewal in Canada*. Toronto, Canada: Author.
- Henderson, S. (2003). Power imbalances between nurses and patients: A potential inhibitor of partnership in care. *Journal of Clinical Nursing*, 12, 501-508.
- Heron, J., & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative Inquiry*, 3, 274-294.
- Holloway, I., & Wheeler, S. (2002). *Qualitative research in nursing* (2nd ed.). West Sussex, England: Wiley-Blackwell.
- Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). West Sussex, England: Wiley-Blackwell.
- Holmes, D. (2005). Governing the captives: Forensic psychiatric nursing in corrections. *Perspectives in Psychiatric Care*, 41(1), 3-12.
- Holmes, D., & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing*, 38(6), 557-565.

Holmes, D., Murray, S., Perron, A., & McCabe, J. (2008). Nursing best practice guidelines:

Reflecting on the obscene rise of the void. *Journal of Nursing Management*, 16(4), 394-403.

Holmes, D., Perron, A., & O'Byrne, P. (2006). Understanding disgust in nursing: Abjection,

self, and the Other. *Research and Theory for Nursing Practice: An International Journal*, 20(4), 305-315.

Holmes, D., Roy, B., & Perron, A. (2008). The use of postcolonialism in the nursing domain:

Colonial patronage, *conversion* and resistance. *Advances in Nursing Science*, 31(1), 42-51.

Honenberger, P. (2007). "Le Nègre et Hegel": Fanon on Hegel, colonialism, and the dialectics

of recognition. *Journal of the Sociology of Self-Knowledge*, 5(3), Article 15.

Hook, D. (2004). *Fanon and the psychoanalysis of racism*. London, England: LSE Research

Online. Retrieved from <http://eprints.lse.ac.uk/2567>

Indian and Northern Affairs Canada. (2008). *Fact sheet: First Nations and Inuit Health in*

Canada. Retrieved from website <http://www.ainc-inac.gc.ca/ai/mr/is/fnihb-eng.asp>

International Council of Nurses. (2006). *The global nursing shortage: Priority areas for*

interventions. Geneva, Switzerland: Author.

Iverson, D. (2003). The logic of Aboriginal rights. *Ethnicities*, 3(3), 321-344.

Jacklin, K. (2009). Diversity within: Deconstructing Aboriginal community health in

Wiwemikong unceded Indian reserve. *Social Science & Medicine*, 68, 980-989.

doi:10.1016/j.socscimed.2008.12.035

- Jackman, D., Myrick, F., & Yonge, O. J. (2010, Spring). Rural nursing in Canada: A voice unheard. *Online Journal of Rural Nursing and Health Care*, 10(1), 60-69.
- Jackson, D., Brady, W., & Stein, I. (1999). Towards (re)conciliation: (re)constructing relationships between indigenous health workers and nurses. *Journal of Advanced Nursing*, 29(1), 97-103.
- Johnson, J. (1991). Nursing science: Basic, applied, or practical? Implications for the art of nursing. *Advances in Nursing Science*, 14(1), 7-16.
- Johnson, J., Bottorff, J. L., & Browne, A. J. (2004). Othering and being Othered in the context of health care services. *Health Communication*, 16(2), 253-271.
- Jones, R. (1995). Why do qualitative research? [Editorial]. *British Medical Journal*, 311. doi: <http://dx.doi.org/10.1136/bmj.311.6996.2>
- Kane, N. (2007). Frantz Fanon's theory of racialization implications for globalization. *Journal of the Sociology of Self-Knowledge*, 5(3), Article 32.
- Kirkham, S. R., Baumbusch, J. L., Schultz, A. S. H., & Anderson, J. M. (2007). Knowledge development and evidence-based practice: Insights and opportunities from a postcolonial feminist perspective for transformative nursing practice. *Advances in Nursing Science*, 30(1), 26-40.
- Kirmayer, L. J., Dandeneau, S., Marshall, E., Phillips, M. K., & Williamson, K. J. (2011, February). Rethinking resilience from Indigenous perspectives. *The Canadian Journal of Psychiatry*, 56(2), 84-91.

- Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples . *Australian Psychiatry*, 11(Suppl.), S15-S23.
- Kirmayer, L., & Valaskakis, G. G. (2009). *Healing traditions: The mental health of Aboriginal peoples in Canada*. Vancouver, Canada: UBC Press.
- Kleiman, A., Das, V., and Lock, M., (1997). *Social Suffering*. Berkley, CA: University of California Press.
- Kristeva, J. (1982). *Powers of horror: Essay on Abjection*. New York, NY: Columbia University Press.
- Kristeva, J. (1986). Word, dialogue and novel. In T. Mori (Ed.), *The Kristeva reader* (pp. 34-61). New York, NY: Columbia University Press.
- Kuhn, T. (1970). *The Structure of the Scientific Revolution* (2nd ed.). Chicago, IL: University of Chicago Press.
- LaRocque, E. (2010). *When the Other is me*. East Lansing, MI: Michigan State University Press.
- Lavoie, J. G. (2004). Governed by contracts: The development of Indigenous primary health care services in Canada, Australia, and New Zealand. *Journal of Aboriginal Health*, 1(1), 6-24.
- Lavoie, J. G., Forget, E. L., & Browne, A. J. (2010a). Caught at the crossroad: First Nations, health care, and the legacy of the Indian Act. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(1), 83-100.

- Lavoie, J. G., Forget, E. L., Prakash, T., Dahl, M., Martens, P., & O'Neil, J. D. (2010b). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Social Science & Medicine*, 71, 717-724. doi:10.1016/j.socscimed.2010.04.037
- Lavoie, J., Gervais, L., Toner, J., Bergeron, O., & Thomas, G. (2011). The Aboriginal health legislation and policy framework in Canada. Prince George, Canada: National Collaborating Centre for Aboriginal Health.
- Leipert, B., & Reutter, L. (1998). Women's health and community health nursing practice in geographically isolated settings: A Canadian perspective. *Health Care for Women International*, 19, 575-588.
- Lemchuk-Favel, L. (1995). *First Nations Health Services, Discussion paper for the Assembly of First Nations health secretariat*. Ottawa, Canada: FAVCOM.
- Lemchuk-Favel, L. & Jock, R. (2004). Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*, 1(1), 28-51.
- Lix, L., Bruce, S., Sarkar, J., & Young, T. K. (2009). Risk factors and chronic conditions among Aboriginal and non-Aboriginal populations (no. 82-003-X). *Statistics Canada Health Reports*, 20(4), p.1-10. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/2009004/article/10934-eng.pdf>
- Local Health Region. (2008). 2007-2008 annual report. Saskatchewan, Canada: Author.
- Local Health Region. (2011). Northern Saskatchewan health indicators report. Saskatchewan, Canada: Author.

- Maar, M. (2004, January). Clearing the path for community health empowerment: Integrating health care services at an Aboriginal health access centre in rural north central Ontario. *Journal of Aboriginal Health*, 54-65.
- Macaulay, A. C. (2009, April). Improving Aboriginal health: How can health care professional contribute? *Canadian Family Physician*, 55, 334-336.
- MacLeod, M., Browne, A. J., & Leipert, B. (1998). Issues for nurses in rural and remote Canada. *Australian Journal of Rural Health*, 6, 72-78.
- MacLeod, M. L., Kulig, J. C., Stewart, N. J., Pitblado, J. R., & Knock, M. (2004, June). The nature of nursing practice in rural and remote Canada. *The Canadian Nurse*, 100(6), 27-31.
- MacMillan, H. L., MacMillan, A. B., Offord, D. R., & Dingle, J. L. (1996). Aboriginal Health. *Canadian Medical Association Journal*, 155(11), 1569-1578.
- Manias, E., & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry*, 7(1).
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, 311, 109-112.
- McAfee, N. (2004). Julia Kristeva. New York, NY: Routledge.
- McBain, L. A. (2006). *Providing care in divided space: Nursing in Northern Saskatchewan 1944-1957 and beyond* (Unpublished doctoral dissertation). Saskatoon, Canada: University of Saskatchewan.
- Memmi, A. (1965). *The colonizer and the colonized* (H. Greenfeld, Trans.). Boston, MA: Beacon Press.

- Mill, J. E., Allen, M. N., & Morrow, R. A. (2001). Critical Theory: Critical Methodology to Disciplinary Foundations in Nursing. *Canadian Journal of Nursing Research, 33*(2), 109-127.
- Ministerial Advisory Council on Rural Health. (2002). *Rural health in rural hands: Strategic directions for rural, remote, Northern and Aboriginal communities*. Ottawa, Canada: Office of Rural Health, Health Canada.
- Ministry of Health and Long-Term Care, Family Health Teams. (2005, September). *Guide to chronic disease management and prevention*. Retrieved from http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_chronic_disease.pdf
- Ministry of Health and Long-Term Care, Primary Health Care Team, Underserviced Area Program. (2011, October). *Tuition support program for nurses*. Retrieved from http://www.health.gov.on.ca/english/providers/ministry/recruit/tuition_doc/prog_guidelines.pdf
- Ministry of Health and Long-Term Care, Rural and Northern Health Care Panel. (2008). *Rural and Northern health care report*. Toronto, Canada: Queen's Printer for Ontario.
- Minore, B., Boone, M., Katt, M., Kinch, P., & Birch, S. (2001). *Facilitating the continuity of care for First Nation clients within a regional context*. Ottawa, Canada: Canadian Health Services Research Foundation.
- Mohammed, S. A. (2006). Moving beyond the 'Exotic': Applying postcolonial theory in health research. *Advances in Nursing Science, 29*(2), 98-109.
- Monette, L. E., Rourke, S. B., Gibson, K., Bekele, T. M., Tucker, R., Greene, S., ... Bhuiyan, S. (2011). Inequalities in determinants of health among Aboriginal and Caucasian

- persons living with HIV/AIDS in Ontario: Results from the Positive Spaces, Healthy Places study. *Canadian Journal of Public Health*, 102(3), 215-219.
- Morley, D., & Chen, K. H. (Eds.). (1997). *Stuart Hall: Critical dialogues in cultural studies*. London, England: Routledge.
- Morrow, R. A. (1994). *Critical theory and Methodology*. Thousand Oaks, CA: Sage.
- Muzio, L. (2013, Summer). RN accountability and responsibility for client care. *SRNA NewsBulletin*, 15(3), 6-8. Retrieved from http://issuu.com/saskrn/docs/srna_nb_summer2013/1?e=2839581/3602848
- National Aboriginal Health Organization. (2005, October). *Ownership, control, access, and possession (OCAP) or self-determination applied to research: A critical analysis of contemporary First Nations research and some options for First Nations communities*. Ottawa, Canada: Author.
- National Collaborating Centre for Aboriginal Health. (2010). *Understanding chronic disease and the role for traditional approaches in Aboriginal communities*. Prince George, Canada: Author.
- National Collaborating Centre for Aboriginal Health. (2011). *Access to health services as a social determinant of First Nations, Inuit and Métis health*. Prince George, Canada: Author.
- Newbold, K. B. (1998). Problems in search of solutions: Health and Canadian Aboriginals. *Journal of Community Health*, 23(1), 59-73.
- Newlands, A. (2000). *Canadian art: From its beginnings to 2000*. Toronto, Canada: Firefly Books.

- O' Hagan K. (2001). *Cultural Competence in the caring professions*. London, England: Jessica Kingsley Publishers.
- Ojakangas, M. (2005). Impossible dialogue on bio-power. *Foucault Studies*, (2), 5-28.
- O'Neil, J. D., Jeffrey, R., & Leeder, A. (1998). Changing the relations of surveillance: The development of a discourse of resistance in Aboriginal epidemiology. *Human Organization*, 57, 230-237.
- Ottawa Charter for Health Promotion. (1986, November). *An international conference on health promotion: The move towards a new public health*. Retrieved from <http://www.phac-aspc.gc.ca/ph-sp/docs/charter-chartre/pdf/charter.pdf>
- Papadopoulos, I. (2003). The Papadopoulos, Tilki and Taylor model for the development of cultural competence in nursing. *Journal of Health, Social and Environmental Issues*, 4(1), 5-7.
- Parliament of the United Kingdom. (1865). *Colonial laws validity act*. London, England: G. E. Eyre & W. Spottiswoode.
- Pauly, B. M., MacKinnon, K., & Varcoe, C. (2009). Revisiting "who gets care?": Health equity as an area for nursing action. *Advances in Nursing Science*, 32(2), 118-127.
- Payne, M. (2001). Knowledge bases and knowledge biases in social work. *Journal of Social Work*, 1(2), 133-146.
- Payne, D., & Nicholls, D. A. (2010). Managing breastfeeding and work: A Foucauldian secondary analysis. *Journal of Advanced Nursing*, 66(8), 1810-1818.
- Perisis, D., Brown, A., & Cass, A. (2008). Addressing inequities in access to quality health care for Indigenous people. *Canadian Medical Association Journal*, 179(10), 985-986.

- Perron, A., Fluet, C. & Holmes, D. (2005). Agents of care and agents of the state: Bio-power and nursing practice. *Journal of Advanced Nursing*, 50(5), 536-544.
- Ploeg J. (1999). Identifying the best research design to fit the question, Part 2: Qualitative designs. *Evidence Based Nursing*, 2, 36-37.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Postl, B., Irvine, J., McDonald, S., Moffatt, M. (1994). *Background paper on the death of Aboriginal peoples in Canada, Bridging the gap: Promoting health and healing for Aboriginal peoples in Canada* (pp.19-56). Ottawa, Canada: Canadian Medical Association.
- Priest, A. (2002, June). Nursing in rural and remote BC. *Nursing BC*, 24-28.
- Quayson, A. (2000). *Postcolonialism: Theory, practice, or process?* Hoboken, NJ: Wiley.
- Racine, L. (2003). Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry*, 10(2), 91-102.
- Racine, L. (2009). Applying Antonio Gramsci's philosophy to postcolonial feminist social and political activism in nursing. *Nursing Philosophy*, 10(3), 180-190.
- Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy*, 88, 222-235. doi:10.1016/j.healthpol.2008.03.015
- Ray, M. (1992). Critical theory as a framework to enhance nursing science. *Nursing Science Quarterly*, 5(3), 98-101.

- Reading, J. (2009). The crisis of chronic disease among Aboriginal peoples: A challenge for public health, population health and social policy. Victoria, Canada: Centre for Aboriginal Health Research, University of Victoria.
- Reed, P. (1997). Nursing: The ontology of the discipline. *Nursing Science Quarterly*, 10(2), 76-79.
- Registered Nurses' Association of Ontario. (2009). *Rethinking health care in rural and northern Ontario: Submission to the rural and northern health care panel*. Toronto, Canada: Author.
- Reimer-Kirkham, S., & Anderson, J. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advances in Nursing Science*, 25(1), 1-17.
- Reimer-Kirkham, S., & Anderson, J. (2010). The advocate-analyst dialectic in critical and postcolonial feminist research: Reconciling tensions around scientific integrity. *Advances in Nursing Science*, 33(3), 196-205
- Richmond, C. A. M. (2007, July/August). Narratives of social support and health in Aboriginal communities. *Canadian Journal of Public Health*, 98(4), 347-351.
- Richmond, C. A. M., & Ross, N. A. (2009). The determinants of First Nation and Inuit health: A critical population health approach. *Health & Place*, 15, 403-411.
doi:10.1016/j.health place.2008.07.004
- Rogers, S., DeGagné, M., Dewar, J., & Lowry, G. (2012). *Speaking my truth: Reflections on reconciliation & residential school*. Ottawa, Canada: Aboriginal Healing Foundation.
- Romanow, R. J. (2002). *Building on values: The future of health care in Canada – Final report*. Ottawa, Canada: Commission on the Future of Health Care in Canada.

Roth, L., d'Haenens, L., & Le Brun, T. (2011). No longer 'the other': A reflection on diversity in Canadian fiction television. *International Communication Gazette*, 73(5), 380-399

Royal Commission on Aboriginal peoples . (1996a). *Report of the Royal Commission on Aboriginal peoples : Gathering Strength* (Vol. 3). Ottawa, Canada: Canada Communication Group.

Royal Commission on Aboriginal peoples . (1996b). *Report of the Royal Commission on Aboriginal peoples : Looking forward, Looking back* (Vol. 1). Ottawa, Canada: Canada Communication Group.

Said, E. (with Bayoumi, M., & Rubin, A. (Eds.)). (2000). The Edward Said reader. New York, NY: Vintage Books.

Sandelowski, M. (2000). Combining qualitative and quantitative sampling, data collection and analysis techniques in mixed-method studies. *Research in Nursing and Health*, 23, 246-255.

Saskatchewan Health, Ministry of Health. (2009). *2008-2009 annual report*. Retrieved from <http://www.health.gov.sk.ca/health-annual-report-2008-2009>

Schegloff, E. (1997). Whose text? Whose context? *Discourse and Society*, 8, 165–87.

Schultz, P. R., & Meleis, A. I. (1988). Nursing epistemology: Traditions, insights, questions. *Image*, 20, 217-221.

Senate Subcommittee on Population Health. 2009. "A Healthy, Productive Canada: A Determinants of Health Approach" - The Standing Senate Committee on Social Affairs, Science and Technology, Final Report of Senate Subcommittee on Population

Health. Retrieved from website:

http://www.cpha.ca/uploads/briefs/pophealth_e.pdf

Sin, D. D., Wells, H., Stenson, L. W., & Man, S. F. P. (2002, June). Asthma and COPD among
Aboriginals in Alberta, Canada. *CHEST*, 121(6), 1841-1846.

Smith, A. (1996). *Julia Kristeva: Readings of exile and estrangement*. London, England:
Macmillan Press.

Smart, B. (2002). *Michel Foucault* (Rev. ed.). New York, NY: Routledge.

Smith, A. (2010, Summer/Autumn). Indigeneity, settler colonialism, White supremacy.
Global Dialogue, 12(2). Retrieved from
<http://www.worlddialogue.org/print.php?id=488>

Smith, D., Edwards, N., Peterson, W., Jaglarz, M., Laplante, D., & Estable, A. (2010).
Rethinking nursing best practices with Aboriginal communities: Informing dialogue
and action. *Nursing Leadership*, 22(4), 24-39.

Smith, J. (2007). Critical discourse analysis for nursing research. *Nursing Inquiry*, 14(1), 60-
70.

Smylie, J., & Adomako, P. (2009). *Indigenous Children's Health Report: Health Assessment in
Action*. Ottawa, ON: FNIHB, Health Canada.

Stanhope, M., & Lancaster, J. (Eds.). (2011). *Community health nursing in Canada* (2nd Cdn
ed.). Toronto, Canada: Elsevier Mosby.

Statistics Canada. (2006). *2006 census: Aboriginal peoples in Canada in 2006: Inuit, Métis
and First Nations, 2006 census: First Nations people*. Retrieved from

<http://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-558/index-eng.cfm>

Statistics Canada. (2007). *2006 census: Aboriginal population profile*. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-594/index.cfm?Lang=E>

Statistics Canada. (2008). *Aboriginal peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/080115/dq080115a-eng.htm>.

Statistics Canada. (2010). *Aboriginal statistics at a glance*. Retrieved from <http://www5.statcan.gc.ca/bsolc/olc-cel/olc-cel?lang=eng&catno=89-645-X>

Statistics Canada, The Daily. (2013, January). *Study: Select health indicators of First Nations people living off reserve, Métis and Inuit, 2007 to 2010*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/130129/dq130129b-eng.htm>

Stevens, P. E. (1992). Who gets care? Access to healthcare as an arena for nursing action. *Scholarly Inquiry for Nursing Practice*, 6(3), 185-200.

Stewart, N. J., D'Arcy, C., Pitblado, J.R., Morgan, D. G., Forbes, D., Remus, G., Smith, B., Andrews, M.E., Kosteniuk, J., Kulig, J. C., & MacLeod, M. L. P. (2005). A profile of registered nurses in rural and remote Canada. *Canadian Journal of Nursing Research*, 37(1), 122-45.

Stewart, N. J., Kulig, J. C., Penz, K., Andrews, M. E., Houshmand, S., Morgan, D. G., MacLeod, M. L. P., Pitblado, J. R., & D'Arcy, C. (2006). *Aboriginal nurses in rural and remote*

- Canada: Results from a national survey* (R06-2006). Saskatoon, Canada: University of Saskatchewan, College of Nursing.
- Stout, M. D., & Downey, B. (2006, September). Nursing, Indigenous peoples and cultural safety: So what? Now what? *Contemporary Nurse*, 22(2), 327-332.
- Swider, S. M. (2002). Outcome Effectiveness of Community Health Workers: An Integrative Literature Review. *Public Health Nursing*, 19(1), 11-20.
- Tang, S. Y., & Browne, A. (2008, April). 'Race' matters: Racialization and egalitarian discourses involving Aboriginal peoples in the Canadian health care context. *Ethnicity & Health*, 13(2), 109-127. doi:10.1080/13557850701830307
- Tarlier, D. S., & Browne, A. J. (2011). Remote nursing certified practice: Viewing nursing and nurse practitioner practice through a social justice lens. *Canadian Journal of Nursing Research*, 43(2), 38-61.
- Tarlier, D. S., Browne, A. J., & Johnson, J. (2007). The influence of geographical and social distance on nursing practice and continuity of care in a remote First Nations community. *Canadian Journal of Nursing Research*, 39(3), 126-148.
- Tarlier, D. S., Johnson, J. L., & Whyte, N. B. (2003, May/June). Voices from the wilderness: An interpretive study describing the role and practice of outpost nurses. *Canadian Journal of Public Health*, 94(3), 180-184.
- Teo, P. (2000). Racism in the news: A critical discourse analysis of news reporting in two Australian newspapers. *Discourse and Society*, 11, 7-49.
- Thorne, S. E. (2008). *Interpretive Description*. Walnut Creek, CA: Left Coast Press.

- Thorne, S. E., Reimer-Kirkham, S., & Henderson, A. (1999). Ideological implications of paradigm discourse. *Nursing Inquiry*, 6, 123-131.
- Thorne, S. E., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, 20 (2), 169–177.
- Tjepkema, M. (2002). The health of the off-reserve Aboriginal population (Catalogue 82-003). *Statistics Canada, Supplement to Health Reports*, 13, 73-88.
- Tookenay, V. F. (1996). Improving the health status of Aboriginal peoples in Canada: New directions, new responsibilities. *Canadian Medical Association Journal*, 155(1), 1581-1583.
- Tyler, W. (1993). Postmodernity and the Aboriginal condition: The cultural dilemmas of contemporary policy. *Journal of Sociology*, 29(3), 322-342
- van Balen, E., & Moffatt, H. (2011, December). *Health planning: Exploring options for rural communities, Workshop summary report*. St. John's, Canada: National Collaborating Centre for Environmental Health.
- van Dijk, T. (1993). Principles of critical discourse analysis. *Discourse and Society*, 4, 249–83.
- van Dijk, T. (1992). Discourse and the denial of racism. *Discourse and Society*, 3, 87–118.
- Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, 18(1), 29-39.
- Vukic, A., & Keddy, B. (2002). Northern nursing practice in a primary health care setting. *Journal of Advance Nursing*, 40(5), 542-548.

- Waldram, J. B., Herring, A., & Young, T. K. (1998). Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives. *Bulletin of the History of Medicine*, 72(2), 343-345.
- Waters, C. (2009, November). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health*, 6-41.
- Weaver, K., & Olson, J. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, 53(4), 459-469.
- Wells, D. L. (1995). The importance of critical theory to nursing: A description using research concerning discourse decision-making. *Canadian Journal of Nursing Research*, 27(2), 45-58.
- Wigmore, M., & Conn, K. (2003, March). Evolving control of community health programs. *Health Canada, Health Policy Research Bulletin*, (5), 11-13.
- Witham, H. (2000). Remote and rural nursing: An endangered profession? *Australian Nursing Journal*, 7(9), 18-21.
- Woods, M. (2013, April). First Nations nursing stations could be forced to close without 'urgently required' staff. *Postmedia News*. Retrieved from <http://o.canada.com>
- World Health Organization. (2005). *Facing the facts: The impact of chronic disease in Canada*. Retrieved from http://www.who.int/chp/chronic_disease_report/media/canada.pdf
- World Health Organization. (2008a). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva, Switzerland: WHO Press.

- World Health Organization. (2008b, August 28). *Inequities are killing people on grand scale, reports WHO's Commission* [press release]. Retrieved from <http://www.who.int/mediacentre/news/releases/2008/pr29/en/>
- Yorks, L., & Sharoff, L. (2001). An extended epistemology for fostering transformative learning in holistic nursing education and practice. *Holistic Nursing Practice*, 16(1), 21-29.

Appendix A

Semi-structured Interview Guide

1. a) Describe your education and career path that led you to being a nurse.

b) What is your current role within the organization, and how long have you worked in this role?
2. What does it mean being a nurse?
3. Please describe your role as a nurse working within the community.
4. What knowledge, attitudes, or skills are helpful to you within your practice?
5. What are the most common preventable health issues that you see?
6. What can you do that will benefit your client's health in the long term?
7. Please describe the challenges that you face in your practice. Please feel free to use examples.
8. a) What resources would be helpful within your work to help improve and maintain your client's health?

b) What barriers affect your work?
9. Please describe any policies that are and would be helpful in guiding your nursing practice.
10. What are some ways that the organization can help support your practice? For example, if you could make a wish for change in the organization, what would it be?

Appendix B

Ethics Approval Certificate

File Number: H06-11-10



Date (mm/dd/yyyy): 08/23/2011

Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Dave	Holmes	Health Sciences / Nursing	Supervisor
Lary	Chartrand	Law / Law	Co-Supervisor
Zaida	Rahaman	Health Sciences / Nursing	Student Researcher

File Number: H06-11-10

Type of Project: PhD Thesis

Title: Nursing the "Other": Exploring the Roles and challenges of Nurses Working within Canadian Rural Northern Communities

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
08/23/2011	08/22/2012	Ia
(Ia: Approval, Ib: Approval for initial stage only)		

Special Conditions / Comments:
N/A



uOttawa

Université d'Ottawa
Faculté des sciences
de la santé

École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Appendix C

Consent Form

Research Project Title:

Exploring the Roles and Challenges of Nurses Working within Rural and Remote Northern Canadian Communities

Principal Investigator:

Zaida Rahaman, Doctoral Candidate, School of Nursing, Faculty of Health Sciences, University of Ottawa

Thesis Supervisors:

Dr. Dave Holmes, Professor, School of Nursing, University of Ottawa

Professor Larry Chartrand, Faculty of Common Law, University of Ottawa

This consent form, a copy of which will be left with you for your records and reference, is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Invitation to Participate:

I understand that the Principal Investigator, Zaida Rahaman, is carrying out research as outlined in the enclosed information letter and that I am invited to participate in the aforementioned research study. I understand that Zaida is a graduate student and as such will be supervised by her thesis supervisors and committee members.

Overview of the Study:

I understand that the purpose of this qualitative study is to explore the roles and challenges of nurses working within Canadian rural Northern communities. Nurses play a central role in the delivery of health services within rural, remote, and Northern Canadian communities. Within these communities, which have a high Aboriginal population, nurses face many challenges in providing essential services where health inequities often contribute to a population that has a greater illness trajectory as compared to the general population.

☎ 613 562-5473
📠 613 562-5443

451 Smyth
Ottawa ON K1H 8M5 Canada

www.uOttawa.ca

I understand that the research will be used in exploring the roles and challenges of nurses within their community context and will be applied in addressing health inequities related to social and historical contexts. I understand that the findings from this research may be used to inform policies guiding nursing practices, and may also be published and/or presented in peer-reviewed journals and/or conferences as a means to share this knowledge with similar settings. I understand that my name from any data used in publications and conferences will be replaced with a code to ensure confidentiality and anonymity.

Participation:

I understand that my participation in this study is voluntary and I am under no obligation to participate. Research questions during the interview will be used to explore the following: 1.) What are the roles and challenges of nurses within Canadian rural Northern communities; and, 2.) What are the individual, organizational, and system level factors that support or impede nurses' work in meeting the community's health and cultural needs. I understand that I will participate in an interview that will last approximately 60 minutes and that the interview will be audio-recorded if I consent, as indicated by the check box below. A second interview will be conducted with the researcher to discuss the results and verify the transcripts. This interview will be approximately 30 minutes long. Both interviews (a total of approximately 90 minutes) will be conducted on my own time. I understand that if I consent to participate in the study, I will contact the Principal Investigator by email or telephone to set a time and place for the interviews. I understand that I do not have to answer any questions that I do not want to, and at anytime I may choose to discontinue the interview. The interviews will tentatively be in September of 2011 within my community setting.

Benefits of the Study:

My participation in this study will contribute to a better understanding of what are the roles and challenges of nurses within Canadian rural Northern communities, and what are the individual, organizational, and system level factors that support or impede nurses' work in meeting the community's health and cultural needs. Nursing knowledge development through qualitative research can lead to a better understanding of nurses' roles and responsibilities, with the ultimate goal of addressing health inequities within Canadian rural Northern communities.

I understand that the benefits of the study may include being able to share my input of my work experiences in contributing to improving work experiences and ultimately having a positive impact on patient outcomes. I understand that another potential contribution is feeling supported within my practice and professional development, and help promote a new pattern of engagement with patients and our community.

Confidentiality and Anonymity:

I am aware that anonymity of my participation cannot be guaranteed due to the close proximity of the community and the likelihood of being observed or having contact with the Principal Investigator. Please note that anonymity of the participants in this study cannot be guaranteed given that the community of nurses is a small one and is in a small general community. In minimizing this risk, I will contact the Principal Investigator via phone or email to set up the interview and choose the location. In addition, conducting the interviews at the participant's home can be an option to help ensure privacy from other participants and non-participants. Interviews can also be conducted via phone with the Principal Investigator on a secured line if the participant chooses not to meet in person. I am aware at any time I can discontinue the interview if feeling uncomfortable or at risk of being judged negatively by others for my participation.

I am aware that if I choose to consent to the interview being audio-recorded, only the Principal Investigator and Thesis Supervisors will use the audiotapes and transcripts and that no other person will have access to them. My name and any other identifying information will be removed from transcripts and a unique code will be used instead. No information will be released or printed that would disclose my personal identity.

Conservation of Data:

All electronic data will be securely stored on the computer used by the Principal Investigator and use of the computer will be protected by a password known only by the Principal Investigator and Thesis Supervisors. Transcriptions of interviews will be secured within a locked file cabinet at the Principal Investigator's Thesis Supervisor office in the School of Nursing at the University of Ottawa. Data will be secured for five years. Methods of destroying the data will include shredding and secure deletion from the primary computer.

Acceptance:

I, _____ (Please print your name), agree to participate in the above research study conducted by Zaida Rahaman, a Doctoral Candidate in the School of Nursing, Faculty of Health Sciences at the University of Ottawa. Any questions I have asked about the study have been answered to my satisfaction. If I have any further questions about the study, I may contact the Principal Investigator or Thesis Supervisors. I have been assured that no information will be released or printed that would disclose my personal identity and that my responses will be completely confidential.

I understand that my participation includes an interview with the researcher as well as a follow-up interview with the researcher to validate my transcripts and discuss the results. Any risks or benefits that might arise out of my participation have also been explained to my satisfaction. In particular, I am aware that my decision to participate or not is voluntary and will not affect my work within the organization. I further understand that I can withdraw from the study at any time without explanation.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON, K1N 6N5.

There are two copies of the consent form, one of which is mine to keep.

I hereby consent to participate in this study:

Yes ☐ No ☐

Contact Information: _____
(Email Address)

Participant Signature: _____ Date: _____

Principal Investigator: _____ Date: _____

Appendix D

Demographic Questionnaire

1. Age:

2. Gender:

☐ Male ☐ Female

3. How long have you lived in your community?

4. How many languages do you speak? _____ Please select all that apply:

☐ English

☐ French

☐ Other _____

5. What is your highest level of education in _____?

☐ College diploma

☐ Undergraduate degree

☐ Graduate degree (Master's, PhD)

☐ Other _____

6. Please select your professional designation:

☐ Licensed Practical Nurse (LPN)

☐ Registered Nurse (RN)

☐ Nurse Practitioner (NP)

☐ Other _____

7. How many years of experience do you have working with the organization?

8. How long have you worked with your current department?

9. Please select your current employment status:

☐ Full-time

☐ Part-time

☐ Casual

Appendix E

Demographic Results

Category		Number (n=25)
Age		Mean: 41.24
Sex	Male	6 (24%)
	Female	19 (76%)
Years of Living in the Community		Mean: 11.55
Language	English	18 (72%)
	Bi-lingual: English & French	1 (4%)
	English & Cree	2 (8%)
	English & Farsi	1 (4%)
	English & Arabic	1 (4%)
	Tri-lingual: English, French, & Cree	1 (4%)
	English, French, & Spanish	1 (4%)
Level of Education	Certificate/ College	7 (28%)
	Undergraduate: Nursing	11 (44%)
	Graduate	6 (24%)
	Other: Medical Degree	1 (4%)
Licensure Affiliation	Licensed Practical Nurse	6 (24%)
	Registered Nurse	16 (64%)
	Nurse Practitioner	1 (4%)
	Other: Medical Doctor	1 (4%)
	Psychology	1 (4%)
Years of Working within their Profession		Mean: 16.6
Years of Working within Current Department		Mean: 7.22
Employment Status	Full-time	25 (100%)

Table E.1.1:
Demographic Information. © Zaida Rahaman, 2014

Programs:	n=25
Integrated Health Services: Acute, Emergency, and Long-term Care	6
Health Promotion: Sexual Health & Wellness	1
Primary Health Care	6
Public Health Nursing	3
Mental Health	1
Home Care	2
Population Health	4
Executive Leadership Team	1
Quality and Risk Management	1

Table E.1.2:

Community- based Programs [Rural and Remote]. © Zaida Rahaman, 2014