

Résumé

Les discours influençant les perceptions des infirmières à l'égard des patients autochtones

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Cette étude explore les discours sociaux et professionnels ayant une influence sur les connaissances et les présupposés des infirmières à l'égard des patients autochtones. Elle est fondée sur un modèle d'investigation ethnographique, des entrevues en profondeur et l'observation des participants. Les données ont été recueillies au cours d'une immersion de neuf mois effectuée par l'auteure dans un hôpital de taille moyenne, situé dans l'Ouest canadien. Trente-cinq participants ont été recrutés grâce à un sondage par choix raisonné, soit des infirmières, des patientes autochtones hospitalisées et des informateurs clés spécialisés en santé des Autochtones. Les résultats indiquent que les perceptions des infirmières à l'égard de leurs patientes autochtones sont façonnées par le chevauchement de trois discours : un discours concernant la culture, un discours professionnel sur l'égalitarisme et un discours populaire sur les peuples autochtones. Ils révèlent que les présupposés culturels sont entrelardés des stéréotypes entretenus par la société dominante et sont parfois présentés comme des faits même lorsqu'ils contredisent les idéaux égalitaires du locuteur. Les conclusions de l'étude mettent en lumière la nécessité de concevoir des stratégies pour stimuler chez les infirmières une réflexion critique sur la culture, le cadre sociopolitique qui détermine les rapports dans le milieu de la santé et, dans une perspective plus large, les discours sociaux ayant une influence sur leurs attitudes.

Mots clés : peuples autochtones, femmes autochtones, Canada, perceptions des infirmières, culture

Discourses Influencing Nurses' Perceptions of First Nations Patients

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This study explores the social and professional discourses that influence nurses' knowledge and assumptions about First Nations patients. Through the use of an ethnographic design, in-depth interviewing, and participant observation, data were collected over a 9-month period of immersion in a midsized hospital located in western Canada. Purposive sampling was used to recruit 35 participants: nurses, First Nations women who were patients in the hospital, and key informants with expertise in Aboriginal health. The findings indicate that 3 overlapping discourses were shaping nurses' perspectives concerning the First Nations women they encountered: discourses about culture, professional discourses of egalitarianism, and popularized discourses about Aboriginal peoples. Cultural assumptions were intertwined with dominant social stereotypes and were sometimes expressed as fact even when they conflicted with egalitarian ideals. Conclusions highlight the need for strategies to help nurses think more critically about their understandings of culture, the sociopolitical context of health-care encounters, and the wider social discourses that influence the perspectives of nurses.

Keywords: Aboriginal peoples, indigenous people, First Nations, First Nations women, Canada, provider-patient relations, nurses' attitudes, culture, colonialism, cultural safety

Health care involving Aboriginal peoples¹ in Canada continues to unfold against a backdrop of colonial relations² that shape access to health care, health-care experiences, and health outcomes. Despite significant

¹ The term "Aboriginal peoples" refers generally to the indigenous inhabitants of Canada, including First Nations, Métis, and Inuit peoples (Royal Commission on Aboriginal Peoples, 1996, p. xii). These three 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" (p. xii). Specifically, the term First Nation replaces the term Indian, Inuit replaces the term Eskimo, and Métis refers to people of mixed European and Aboriginal ancestry. The labels "Native" and "Indian," however, continue to be used in federal legislation and policy (e.g., the *Indian Act*), statistical reports, and public discourses. In 2001, 1.3 million people, or 4.4% of the total Canadian population, reported Aboriginal ancestry (Statistics Canada, 2003).

In this paper, the term "Aboriginal peoples" is used to refer generally to the diverse groups within Canada. First Nations is used more specifically to refer to the participants in the study who identified as First Nations.

² Kelm (1998) discusses colonization from a historical perspective as the "sociocultural dislocation, the establishment of external political control and economic dispossession,

improvements in recent years, the health of Aboriginal peoples continues to lag behind that of the overall Canadian population on virtually every measure (Canadian Institute for Health Information [CIHI], 2004). Scholars across all sectors of Aboriginal health research concur that persistent disparities in health and social status are entrenched in the history of relations between Aboriginal peoples and the nation-state (Adelson, 2005; Dion Stout, Kipling, & Stout, 2001; Kelm, 1998).

In Canada, O'Neil's (1989) hallmark study of health-care encounters involving Inuit patients and Western care providers has been highly influential in drawing attention to the political context of patient-provider relations. By situating individual patient-provider interactions in the internal colonial context of health-care provision in northern Canada, O'Neil demonstrates how paternalism, power differences, and cultural misunderstandings are shaped by wider sociopolitical issues. O'Neil argues further that the tendency of Western nurses and doctors to "bracket out" the sociopolitical context of health-care encounters stems from their professional socialization and their predominantly middle-class values.

Most of the research on health-care encounters involving Canadian Aboriginal patients subsequent to the publication of O'Neil's (1989) work has been conducted from the perspective of patients (Baker & Daigle, 2000; Browne, 1995; Browne & Fiske, 2001; O'Neil; Sherley-Spiers, 1989). For example, Browne and Fiske found that some women were acutely aware of their gendered stereotyping as First Nations women by health-care providers. Findings from this and other studies demonstrate the need to locate the micropolitics of health care within sociopolitical and historic contexts. Research conducted from the vantage point of patients is critical to improving the provision of services. Such research shows that it is equally important to explore how it is that health professionals come to hold the knowledge and assumptions that

the provision of low-level social services, and finally, the creation of ideological formulations around race and skin colour" (p. xix). In the current context, LaRocque (1993) defines colonization from an Aboriginal perspective as the "loss of lands, resources, and self-direction and...the severe disturbance of cultural ways and values" (p. 73). It should be kept in mind, however, that colonizing forces did not operate as a single, uniform trajectory of subjugation — oppositional voices and resistance also existed: "The processes of power inherent in colonization [are]...diffuse, dialectical, and subject to competing positions both from within the society of the colonizers and from the colonized" (Kelm, p. xviii). Further, Furniss (1999) argues that what characterizes colonial culture in Canada is "not merely the presence of racist discourses" but also the distinctions drawn between Aboriginal and non-Aboriginal peoples through the assignment of "difference — negative, neutral or positive — or through the denial of difference.... These alternating tendencies toward...assertion and denial of indigenous differences are central dynamics within colonial discourses and practices" (p. 13).

shape their views of particular patients or patient groups. The present study takes up this challenge by exploring the social and professional discourses that influence nurses' knowledge and assumptions about the First Nations patients they encounter in hospital.

Several concepts central to this paper require defining at the outset. Discourse can be defined as a "coherent way of describing and categorizing the social world" through patterns of "words, figures of speech, concepts, values, and symbols" (Lupton, 1994, p. 18) or as a "domain of language-use that is characterised by common ways of talking and thinking about an issue (for example, the discourses of medicine)" (Germov, 1998, p. 341). Further, "it is through discourse that social reality comes into being" (Escobar, 1997, p. 85).

The notion of "dominant culture" is also central to this paper. Furniss (1999), a Canadian anthropologist, describes dominant culture as a "deeply rooted set of understandings" that is experienced as a "set of common-sense, taken-for-granted truths" about individuals, society, and social relationships (p. 14). This does not imply that there is a unitary dominant culture, that all people subscribe to dominant cultural assumptions, or that these assumptions are static or fixed. However, various kinds of dominant cultural assumptions infuse many aspects of everyday life — through the media, schoolbooks, public interest debates, and everyday conversations. They shift and change according to one's life context, the local issues of which they are a part, and current political and economic contexts. Hence the "different life experiences of individuals, conditioned not only by their individual biographies but also by their varied positions within structures of inequality...give rise to different perceptions" that challenge the legitimacy of a dominant culture (p. 14–15).

The concept of culture also requires close analysis. In nursing and health care, culture is commonly understood as "a template or blueprint for human behaviour, grounded in the values, beliefs, norms, and practices of a particular group that are learned or shared" (Reimer Kirkham & Anderson, 2002, p. 4). Several nurse researchers have written extensively on the limitations of this perspective, arguing that culture is much more complex³ than is typically assumed (see, e.g., Allen, 1999; Anderson, 1998; Anderson & Reimer Kirkham, 1999; Culley, 1996; Doane & Varcoe, 2005; Meleis & Im, 1999; Reimer Kirkham et al., 2002). Allen argues that culture cannot be reduced to a set of fixed, identifiable characteristics or traits attributable to members of a particular ethnocultural group. Culture can, however, be understood as a shifting, changing, relational process that is lived within and among groups and

³ As Margaret Lock (1993) points out, "culture" is "one of the two or three most complicated words in the English language" (p. 144).

people, and therefore as deeply enmeshed in power relations and in economic, political, and historical contexts (Anderson & Reimer Kirkham; Doane & Varcoe; Stephenson, 1999). The scholars cited above point to the problems that can arise when health-care providers are taught to watch for particular cultural traits or cultural differences, arguing that notions of difference are always set against presumed (dominant) cultural norms. This practice tends to reinforce ideas about “us and them,” “normal and different,” “typical” or “Other.”⁴ Despite an increasing number of critiques in nursing and health care, culture continues to be viewed as synonymous with “difference,” without a full appreciation of how these differences can reflect widely held stereotypes. Compounded by the propensity to view culture as equivalent to ethnicity or nationality, culture tends to be seen as relevant only to people who differ from the dominant group. It is in this context that ideas about culture have the potential to become problematic in nursing.

Social Determinants of Aboriginal Women’s Health

In Canada, the complex history of colonial politics, policies, and practices has resulted in profound social and cultural disruption within many Aboriginal communities, marginalization of many Aboriginal people in terms of the wage economy and mainstream political processes, and the forced economic dependence of many Aboriginal peoples on the nation-state (Kelm, 1998; Waldram, Herring, & Young, 1995). The regulation of Aboriginal peoples’ lives through social policies embedded in the *Indian Act*, the restrictions placed on Aboriginal self-government, land claims, and the economic development of Aboriginal communities are vestiges of the colonial past (Armitage, 1995) that, in turn, shape life opportunities, economic conditions, and the overall health and social status of individuals, families, and communities. According to leading scholars in Aboriginal health,

Despite public recognition of past injustices committed against Aboriginal peoples in this country, marginalization and prejudice remain very much present in the daily lives of many community members. While the effects of this marginalization make themselves manifest in any number of ways, few are more telling than statistics that place

⁴ Othering refers to the projection of assumed cultural characteristics, differences, or identities onto members of particular groups. Othering is also a process through which we construct our own identities in reference to Others (Varcoe & McCormick, in press). By identifying individuals or groups as Other, one magnifies and reinforces projections of apparent differences from oneself (Johnson et al., 2004). As Ahmad (1993) explains, by “defining the Other (usually as inferior) one implicitly defines oneself against that definition (usually as normal or superior)” (p. 18).

Canada's Aboriginal population far below their non-Aboriginal counterparts in the United Nations Human Development Index. (Dion Stout et al., 2001, p. 12)

The colonial legacy of subordination of Aboriginal peoples has resulted in multiple jeopardy for many Aboriginal women, who face personal and institutional discrimination and disadvantage on the basis of race, gender, and class (Browne & Fiske, 2001; LaRocque, 1996; Native Women's Association of Canada [NWAC], 2002). Despite improvements in recent years, health and social status indicators continue to demonstrate large discrepancies between Aboriginal and other Canadian women (CIHI, 2004; Dion Stout et al., 2001). For example, age-standardized mortality rates from all causes for Aboriginal women are substantially higher than those for other women. Life expectancy for Aboriginal women is 76.2 years, versus 81.0 years for non-Aboriginal women (NWAC). The incidence of low income among Aboriginal women is more than twice that among the general female population (42.7% vs. 20.3%) (Dion Stout et al.), and the economic situation for Aboriginal lone mothers is even more grave (NWAC). The current crisis caused by extremely high rates of HIV among Aboriginal women is one of the most devastating manifestations of the cumulative effects of poverty, dispossession, powerlessness, and despair (Health Canada, 2002; Spittal & Schechter, 2001). These social and health inequities cannot be glossed over as lifestyle or cultural issues; they are manifestations of the complex interplay of historical, social, political, and economic determinants of health status and access to health care.

Colonizing Assumptions About Aboriginal Women

To explain how the marginalization of Aboriginal women was rationalized in the past, scholars are drawing attention to the ways in which colonial images were used to manipulate public opinion. For example, images of Aboriginal women as dissolute, neglectful, and irresponsible helped government officials in the past to justify the extreme levels of poverty and ill health in many Aboriginal communities, creating misrepresentations that "blamed First Nations women for their lot in life and justified state intervention" (Stevenson, 1999, p. 66). Colonizing images of Aboriginal women as irresponsible and incompetent contributed to the "inferiorization of Aboriginal motherhood" and fuelled the widespread practice in the 1960s and 1970s of placing Aboriginal children in non-Aboriginal foster homes (Fiske, 1993, p. 20). More recently, public awareness campaigns portraying fetal alcohol syndrome as a primarily Aboriginal health problem have been criticized for perpetuating the public and professional perception of Aboriginal women as negligent and

uncaring (Tait, 2000a, 2000b). Negative images from the past endure today as stereotypes (Eisenberg, 1998; Green, 1995; Gunn Allen, 1995; Newhouse, 2004; Stevenson; Tait, 2000b). As social tensions continue to rise in the competition for diminishing economic resources, misinformation about Aboriginal peoples is becoming even more visible, as issues related to land claims, rights, and entitlements are debated in public venues (Furniss, 1999). An editorial in a major Canadian newspaper serves to illustrate these public discourses:

It's called a culture of entitlement and a whole lot of Canada's aboriginals have it real bad. Those who suffer from this energy sapping affliction almost always grow lethargic and passive.... Even the label "First Nations" speaks of entitlement, as though all others are second in line... The truth is, however impolitic it may be to say it, pandering to Native Indians has become a virtual industry in this country. (Yaffe, 2002, p. A14)

This is not an isolated diatribe. Furniss (1997/98, 1999), Dunk (1991), Newhouse, and Ponting (1997, 2001) document the extent to which assumptions about Aboriginal peoples as wards of the state are expressed matter of factly in the media and in everyday conversation as popularized public viewpoints. These dominant cultural discourses — generated in the wider social world — can also shape the perspectives of health-care providers, and the knowledge and assumptions they hold about the patients they encounter in the clinical setting.

Research Methods

In this paper I discuss one aspect of the findings of a larger study exploring the sociopolitical context of health-care encounters between nurses and First Nations women. Specifically, it focuses on the wider social discourses that were found to influence nurses' interpretive perspectives. "Interpretive perspectives" refers to the various types of knowledge, assumptions, and experiences that shape nurses' understandings of their patients. Elsewhere, I discuss how these perspectives affected nurses' interactions with patients and their practices with regard to patients (Browne, 2003). Because of the need to limit the scope of the paper, the perspectives of the First Nations patients are also reported elsewhere (Browne).

Using an ethnographic design and in-depth interviewing and participant observation, data were collected over a 9-month period of immersion in a midsized hospital located in a western Canadian city. Aboriginal peoples comprised 9% of the city's population, compared to an average of 3% in other cities in the same province (Statistics Canada, 2003). Because of these demographic characteristics, this particular

hospital setting was well suited to the exploration of health-care encounters between nurses and First Nations women.

Theoretical Perspectives Informing the Study

The study was informed by an emerging body of inquiry in nursing scholarship that draws on postcolonial theoretical perspectives (Anderson, 2000, 2002, 2004; Anderson et al., 2003; Browne & Smye, 2002; Browne, Smye, & Varcoe, 2005; Doane & Varcoe, 2005; Reimer Kirkham & Anderson, 2002; Varcoe & McCormick, in press). Postcolonial theories can be understood as forming a body of critical perspectives that share a political and social concern about the legacy of colonialism, and how this legacy shapes relations at the individual, institutional, and societal levels (Young, 2001). As McConaghy (2000) explains, "the term postcolonial does not refer to a period of time, that is, the period of history after colonialism. Rather, the post in postcolonial refers to a notion of both working against and beyond colonialism.... Postcolonial therefore refers to issues of power, rather than time" (p. 268). Of central concern in postcolonial scholarship are analyses that shed light on how conceptions of race, racialization, and culture are constructed in particular sociopolitical contexts and shape contemporary social life, including relations in health care (Anderson, 2004). Exploration of these issues is particularly relevant in the Canadian context, where historically established relations of power, authority, and paternalism continue to shape health-care policies and practices concerning Aboriginal peoples (Adelson, 2005; Browne et al., 2005; Kelm, 1998; O'Neil, 1989; Waldram et al., 1995). In applying postcolonial theoretical perspectives, the goal is to use theory not as "the container into which the data must be poured" (Lather, 1991, p. 62), but rather as an interpretive lens through which to analyze the findings (Sandelowski & Barroso, 2003; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004).

The Participants

Purposive sampling was used to recruit a total of 35 participants. These included 14 registered nurses (RNs) and two licensed practical nurses (LPNs) who worked at the hospital, 14 First Nations women who were their patients in the hospital, and the Native liaison worker employed at the hospital. The nurses were recruited by inviting those who were assigned to care for First Nations women (in addition to their other patients) to participate in the observations and interviews. After a significant proportion of the data had been collected and analyzed, four key informants with expertise in Aboriginal health were invited to discuss aspects of the data and to provide feedback on the preliminary themes. These included two RNs and a community health representative, all of

whom worked in a nearby reserve community, and a health administrator responsible for First Nations health care in the region. Each of the key informants self-identified as First Nations. All of the participants were women.

Among the hospital nurses ($n = 16$), six had been employed at the hospital for between 15 and 25 years, eight for between 5 and 10 years, and two for less than 2 years. Two held baccalaureate degrees, three were in the process of completing BSN degrees, and the remainder were diploma-prepared. All worked either full time or nearly full time. The majority were experienced clinicians: on average, they had 16.5 years of nursing experience (range 2–25 years). Their average age was 43.8 years (range 25–58 years). All but two had lived and worked in this city or in the vicinity for several years (range 3–30+ years). Four self-identified as First Nations and the remainder as Euro-Canadian.⁵ To protect anonymity, particularly for the two LPN participants, the term “nurse” is used to refer to both RNs and LPNs except where specific distinctions are required.

Data Collection

The study was approved by a university and hospital ethics board. The nurses and the First Nations women they were assigned to care for provided written informed consent before participating in interviews or the participant observation components. All data were collected by the principal investigator with the exception of data collected in three interviews conducted by two trained research assistants.

Participant observation involved the researcher’s accompanying RNs during day and night shifts as they provided care to a variety of patients, including First Nations women. Observations were conducted on medical-surgical, renal, and postpartum units in order to ensure maximum variation, among both nurses and patients, in terms of different areas within the hospital. Participant observation provided the researcher with an opportunity to observe the patterns of interactions between nurses and patients, listen unobtrusively, and engage in dialogue with nurses and patients. Observation was essential to developing insights into the contextual factors that informed nurses’ perspectives, the institutional context, and the challenges faced by the nurses as they provided

⁵ Although “white” is the more common colloquial term used in Canada to distinguish non-Aboriginal peoples, Furniss (1999) states that Euro-Canadian is “the accepted term in formal academic discourse to refer to the dominant segment of Canadian society” (p. xi). Extending Furniss’s rationale, I draw on Frankenberg’s (1993) conceptualization of white (in this case, as synonymous with Euro-Canadian), to signal “a location of structural advantage, of race privilege...a ‘standpoint’, a place from which white people look at ourselves, at others, and at society” (p. 1).

care to various patients. Observational data were recorded as field notes. Field notes also contained reflexive analyses on how the researcher's professional, social, and ethnocultural positioning may have influenced the research process and the dynamics of her interactions with participants.

Because the data were collected over a period of 9 months, I had numerous opportunities to connect with nurses informally during coffee or lunch breaks or during shift reports. During the observational sessions, I remained in the role of researcher and did not participate as a practising nurse. However, as a clinician I often alerted nurses to changes in patients' status and assisted nurses with non-clinical tasks. In relation to patients, I often brought tea, ice chips, or snacks if permitted, helped to adjust their bedding or their position in bed, or discussed the health-related concerns they raised. In these ways, I assisted the nurses and patients as needed but did not get involved in the practice of clinical nursing per se. Nonetheless, on several occasions nurses asked my opinion as they engaged in clinical decision-making, and I responded based on my clinical expertise.

In ethnographic research, it is important that the researcher reflect on the extent to which his or her presence affects the process of data collection. During the observational sessions in this study, I noted that the nurses did not seem to be spending extra time talking or lingering with patients, or making special efforts to connect with them beyond what was required during routine care, because of the hectic pace and the volume of their work. In other words, the nurses seemed not to alter their pace or manner of interacting with patients or each other on account of my presence. In fact, most of the nurses' encounters with patients occurred during brief, almost fleeting, moments as they rushed from patient to patient. Often, it was when they were not at the bedside — for example, when they were at the nurses' station, at the charting desk, or in medication and supply rooms — that nurses would spend a few moments reflecting on the process of providing care. On a few occasions nurses who felt particularly overburdened and pressed for time asked me to defer the observational session to a subsequent shift. On other occasions they commented on how "easy" it was to have me shadow them. Although it is never possible to definitively determine the authenticity of research participants' behaviours, the use of a variety of data-collection methods (for example, participant observation and individual interviews) provided a more comprehensive portrayal of nurses' encounters with patients than would be possible with any single data-collection method (Silverman, 1998; Thorne et al., 2004).

In-depth interviews were conducted with nurses who participated in observational sessions, in order to explore their experiences and perspec-

tives in relation to the First Nations women they cared for in hospital. The majority of nurses chose to be interviewed on their days off and at a location other than the hospital (e.g., in the researcher's office). The interview guide included open-ended, broad "trigger" questions (intended to stimulate discussion) (Spradley, 1979). First, nurses were asked what it was like to work in the hospital and to describe the range of patients they encountered in their work. As the interview progressed, they were asked to describe their experiences caring for the First Nations women they encountered as patients. Throughout the interview, nurses were asked to ground their discussion in examples and to reflect on situations that they found particularly positive and those that were more challenging. Additional questions were formulated during the interview in response to nurses' accounts. Since the interviews took place some days after the observational sessions, questions specific to the observational sessions were also posed. This created an opportunity to ground the interview in the context of nurses' everyday practice. Follow-up interviews were conducted to clarify and verify information discussed in the initial ones. All interviews were audiotaped and transcribed verbatim.

Data Analysis

An interpretive thematic analysis was completed using processes described for qualitatively derived data (Sandelowski, 1995; Thorne et al., 2004). Coding and analysis was facilitated by the use of NVivo, a computer program for organizing, contrasting, and comparing qualitative data. Consistent with interpretive inquiry, data analysis was an iterative process of moving back and forth between the data as they were collected and coded. As data were continually gathered, interviews and field notes were read repeatedly to identify recurring and contradictory patterns in the data, preliminary concepts and themes, and possible linkages to theory. Concepts and themes were developed and used to categorize and code the data. As more data were collected and coded, categories were collapsed, expanded, modified, and refined. All data were coded by the author; in addition, interview transcripts were independently coded by two trained research assistants in order to identify similarities and differences. Discrepancies in coding served to identify areas for further exploration and led to further refinement of the coding categories. In the final stages, the analysis shifted to a more theoretical level of conceptualizing the ideas and themes expressed in the data (Sandelowski & Barroso, 2003).

Scientific quality and trustworthiness of the analysis were assessed through triangulation of multiple data sources (Thorne et al., 2004). Observational data contributed to the validity of findings by providing a form of triangulation that created a context within which to interpret

the interview data — and vice versa. Relevance and credibility of the data were evaluated by reviewing the emerging analysis with several of the hospital nurses and the four key informants, who provided feedback on the ways in which the preliminary themes resonated with their perspectives or experiences. Throughout the study, reflexive analyses were recorded in field notes as a way of critiquing how the researcher's assumptions, values, and perspectives influenced the research process and interpretation of findings (Emerson, Fretz, & Shaw, 1995; Harding, 1987). At all stages of the study, an auditable decision trail of analytical and interpretive pathways was maintained.

Findings

Nurses and other health-care providers are influenced by a variety of theoretical and ideological perspectives garnered through their educational programs, accumulated professional experience, popularized public discourses, and societal experiences. Nurses thus draw upon a range of interpretive perspectives as they provide care to an increasingly diverse spectrum of patients. In this study, three overlapping discourses seemed to be shaping the nurses' interpretive perspectives and their understanding of the First Nations women they encountered: (a) discourses about culture, (b) professional discourses about egalitarianism, and (c) popularized discourses about Aboriginal peoples. While these discourses are discussed separately in the analysis that follows, they were not mutually exclusive; rather, they intersected to form complex and often contradictory interpretive perspectives. Consistent with interpretive inquiry, I interwove literature with the findings in order to form linkages between the empirical data and relevant theoretical perspectives (Sandelowski & Barroso, 2003; Thorne et al., 2004).

Discourses About Culture

The nurses were well aware that attending to issues of culture is an essential component of quality nursing care, and culture figured strongly in many aspects of their discussions. They stressed the importance of developing a better understanding of their patients' cultural backgrounds and saw "cross-cultural training" as a means of improving their practice:

[We are] getting better... The more we're learning about different cultures and having the cross-cultural classes in the nursing schools...experience helps; working with different cultures...helps a lot too.

Several nurses discussed cross-cultural training as a means of developing a non-judgemental approach in their practice:

One of the things they teach you in nursing is to be non-judgemental. You can't help somebody if you're busy judging them for what they're doing. It's the same with Native people. You can't help them if you're judgemental in the way you approach them.... And a lot of that is non-verbal, non-spoken.

A common belief in health care is that more cross-cultural training is needed, to help providers move beyond their judgements about certain patients. The nurses who felt they were not offered enough cross-cultural training opportunities described their work with some First Nations patients as “more challenging.” One nurse described a commitment to treating all patients equally despite her sense of having to work from a deficit position in terms of cultural knowledge:

Everybody has cultural beliefs and practices that you have to take into consideration. So that's always a challenge — and more of a challenge for me, because I didn't have any training in those things.

In an attempt to elicit cultural information from patients, nurses used an open-ended item on the hospital's admission form asking about “cultural practices”:

Whenever a patient comes onto the ward, we do a complete history... and we talk to them about cultural and religious practices and how they feel the hospitalization will impact on that... Most people do respond, and say there are no issues.

The purpose of the “cultural practices” item is to focus attention on issues of culture, the implication being that cultural information can be efficiently and easily elicited from patients. Consistent with prevailing conceptualizations of culture in health care, such institutional practices reinforce the notion of culture as something readily identifiable and easily addressed during routine health care (Allen, 1999). It is not the intent behind the item that is problematic but, rather, the *effect* of the item in reinforcing the notion of culture as quite narrowly defined in relation to the values, beliefs, and practices that are inherent to particular groups of people. When culture is represented in this way, it tends to be thought of as existing outside of power relations, or outside of people's social or economic circumstances (Doane & Varcoe, 2005). As the findings continued to show, narrow conceptualizations of culture can, paradoxically, reinforce the stereotyping of people who belong to particular ethnocultural groups — in this case Aboriginal patients.

As nurses discussed the diverse patients they encountered in the hospital, including First Nations women, they struggled to speak sensi-

tively about the social problems affecting some of their patients. One nurse grappled to find the appropriate phrasing:

I find with Native people, just the way their culture is, I think you get a lot more social things that you need to deal with, a lot of — not necessarily problems but... [pause] What am I thinking of?... [pause] They are very complex socially and you need to look at a lot of things.

As the interview progressed, this nurse provided some examples of the social issues alluded to above. For example, she commented, “It is in their culture to have a lot of violence, stabbing, alcohol abuse... more than what you see in other cultures.” She also reiterated that this “doesn’t mean that all Native people are drinking or in violent situations” but that there seemed to be more of those issues in First Nations culture.

Equating social problems with cultural characteristics is not uncommon in health-care discourses. Reflecting a proclivity for culturalist discourses in health care generally, culture is often given as the primary explanation for why certain people or groups experience various health, social, or economic problems (Reimer Kirkham et al., 2002). Culturalist discourses run the risk of shaping the perspectives of health-care providers by conveying the message that social problems such as alcoholism, dependency, and unemployment are largely a reflection of a group’s cultural characteristics. They are infused with socially constructed assumptions about cultural essentialism — whereby a group’s values, lifestyles, or beliefs are seen as reflecting inherent cultural characteristics. When health-care providers have frequent contact with patients who embody social problems (e.g., alcoholic patients), and when these patients are associated with a particular ethnocultural group, it can be challenging *not* to assume that social problems are culturally based. Because of the relatively narrow conceptualization of culture, the tendency in culturalist discourses is to overlook the broader structural, economic, and historical contexts that shape social and health problems.

Many of the nurses appeared to be strongly influenced by these cultural discourses. For example, a nurse reflecting on a challenging discharge-planning process for a First Nations woman from a reserve community commented: “She didn’t take care of any of her own responsibilities [at home]. She didn’t look after her own child. Now, I know that is a cultural thing.” The tacit linking of maternal irresponsibility⁶ with First Nations culture was one of several ways in which culturalist

⁶ Aboriginal and non-Aboriginal scholars argue that historically mediated images of Aboriginal women as irresponsible mothers persist today as popularized stereotypes (Eisenberg, 1998; Green, 1995; Gunn Allen, 1995; Newhouse, 2004; Stevenson, 1999; Tait, 2000b).

discourses manifested in clinical conversations and reflected negative stereotyping. The limitation of a culturalist perspective lies in its tendency to overlook the socio-economic and historical issues (e.g., violence, poverty, intergenerational trauma) that place certain persons at risk. In a similar vein, culturalist discourses that conflate alcoholism with Aboriginal culture, as manifested in some of the nurses' comments that "quite often in this culture, they drink a lot" further mark Aboriginal peoples as stereotyped, cultural Others. Again, there is the tendency to overlook the socio-economic and historical conditions that can give rise to some people's experiences of poverty or substance use. These narrow understandings of culture, which are pervasive in health care, constrained the nurses' analyses of the wider structural, historical, and social contexts that shape people's lives, life opportunities, and access to the resources for health.

Professional Discourses About Egalitarianism

As the nurses discussed the diverse patients they encountered, they reiterated that they were committed to treating all patients equally. Reflecting a widely held professional discourse about the importance of egalitarianism (Canadian Nurses Association, 2002), many concurred with a sentiment expressed by one of their colleagues: "I treat nobody of a different culture any differently. I treat people equally, all the same."

Consistent with "colour blindness" as an appealing and powerful professional discourse, the principles of egalitarianism assume that all people should be — and in most cases are — treated the same regardless of their social, ethnocultural, or gendered location (Henry, Tator, Mattis, & Rees, 2000). Discourses about egalitarianism convey the message that, generally speaking, health-care systems and institutions are fair and treat people equitably. Many of the nurses expressed this idea, commenting that inequities in relation to Aboriginal patients were a "thing of the past... We're all smarter than that now. That is no longer acceptable."

In some cases the interview process itself served as a catalyst for nurses to reflect critically on the ideals of egalitarianism. Provided with an opportunity to reflect on their experiences, some nurses began to question their own level of awareness:

Many people, a lot of times, get categorized. That would probably be the only thing... And I find quite frequently people may jump to the conclusion that if someone [a patient] drinks, they categorize Native people as drinking quite frequently. I guess in one way you can call that a little prejudiced.... But other than that, I don't see people being prejudiced in any way.

Another nurse stated that materials she was studying in an ethics course helped her to think critically about the precepts of egalitarianism. As she discussed her work with some of the First Nations women who were her patients, she drew distinctions between the need to treat all patients equally and the need to tailor services and care to specific groups, to rectify past injustices and present inequities. This level of analysis contrasted with the responses of some other nurses who expressed the view that “here, everyone is treated equally.”

Other nurses pointed to more explicit challenges to egalitarianism operating in health-care encounters. One nurse whose interpretive lens was shaped partly by her experiences as a First Nations woman described her sensitivity to seemingly innocuous comments made on the wards:

It's really hard for me to talk about [it]. I think to myself, it shouldn't bother me.... There are comments, not directly about one particular patient but comments in a general sense.... I've heard, just as I'm charting, something like, “Oh, they [Aboriginal patients] get all their medications paid for,” “no taxes,” and things like that.... And I don't respond to those because this is where I work. I don't need this kind of stress.

It was not only the First Nations nurses who reflected critically on the notion of “equal treatment for all.” One nurse described her colleagues’ “feelings” (as she sensed them) about their work with First Nations patients:

You get your good and your bad. You get a couple who...don't want to know any more. But most of them are professional enough — if they do have those feelings, they go in and do their jobs and leave. I have seen nothing really overt. I have heard a few comments...I know that the feelings are there.

Several nurses expressed faith in “professionalism” as the mechanism by which their colleagues would manage their “feelings” towards particular patients. To keep one’s biases in check — to “not let it show in your work,” in the words of one nurse — was often framed as a professional responsibility:

Individuals have individual perceptions, individual biases, depending on how you were brought up, what you experienced in life. You have to make up your mind that you're going to try as much as you can to treat everybody equal. And sometimes it becomes hard. You may generalize. I mean, people generalize all the time. So it's a very individual thing, and in nursing you have to be careful.

The idea that one can achieve egalitarianism by remaining professional serves to place the responsibility firmly on the shoulders of individuals.

However, focusing on biases as individually held opinions obscures the ways in which individual opinions are actually connected to — and reflections of — much wider social discourses. Wider social discourses can and do exert an influence on nurses' interpretive perspectives, despite personal commitments to the ideals of egalitarianism or professionalism.

Popularized Discourses About Aboriginal Peoples

Awareness of how dominant social views can be given expression through seemingly tolerant democratic discourses helps to explain why some nurses can view “all patients as equal” and, at the same time, view some Aboriginal patients as negative stereotypes. For example, discourses about respect and egalitarianism were sometimes discussed in parallel with constructions of Aboriginal people that reflected popularized negative stereotypes. One nurse described her approach to caring for some patients and the challenges she perceived:

I don't approach them [Aboriginal patients] any differently.... I look at them as individuals.... Respect, just show them respect. Have an empathetic attitude. But I also don't let them get away with a lot of what they try and get away with. For example, I find drugs and alcohol are real big problems with First Nations.... It's kind of sad.

Despite the inherent contradictions in this comment, it is apparent that the critical issue is not the individual beliefs expressed but the extent to which the nurse's thinking is *organized* by racialized assumptions. The image of the “drunken Indian” is one of the most enduring colonizing images pervading Canadian society (Furniss, 1999, p. 107). This stereotype cannot be accounted for as an individually based opinion; rather, it has its origins within the domains of public history, which continue to shape Canadian consciousness.

Canadian social discourses that represent Aboriginal peoples as dependent, as “getting everything for free,” or as undeserving recipients of government programs are pervasive in the media, in public debates, and in everyday conversation (Furniss, 1999; Newhouse, 2004; Ponting, 1997). The nurses in this study who were concerned that Aboriginal people “get everything paid for” were reflecting social views expressed more widely. In the absence of strategies or opportunities to think critically about these issues, nurses sometimes drew on powerful dominant discourses to form their understanding of the First Nations patients they encountered in the hospital:

I just don't think that throwing large sums of money without any direction or any guidance or any programs helps people who have been sidelined for

a long time. They don't have to pay taxes. They don't have to work. That's how they live. And I think the government precipitates that.

This view bears a striking resemblance to that expressed in the newspaper editorial cited earlier. In the absence of a broad base of knowledge about the economic and historical issues that have contributed to marginalization from the wage economy, or about the necessity for some communities to rely on government subsidies to maintain a basic standard of living, it can be a challenge to see “dependency” as anything other than a cultural way of life. As one nurse said:

The government gives them land, pays for their school. What do they have to do? And that filters right on through to when they come in here [the hospital]. They expect you to give because they are used to having it handed to them.... And as a result they don't have a bottom line, maybe the way you and I would have.

One of the features of popularized assumptions — particularly in relation to ethnocultural groups — is the way in which they feed into the “us/them” binaries so characteristic of these wider social discourses. Popularized assumptions about Aboriginal peoples tend to portray a self-reliant member of the dominant culture on the one hand and a dependent, irresponsible Other on the other hand. Underlying such constructions is the view that people should be able to overcome social problems, become self-sufficient, and assume personal responsibility for their lifestyles.

These wider social perceptions serve as a lens through which patients' individual circumstances are interpreted. In everyday clinical practice, seemingly innocuous comments can resonate with socially constructed messages. A First Nations nurse recounted her experience caring for an indigent First Nations man who had just been admitted to a ward:

He was just covered in dirt from head to toe, so we did what we could and made him comfortable. I felt that everybody was working together. Everybody was doing what was required of them. But then, as we were leaving [the room], somebody made a comment... “There is your argument for land claims.” And the conversation kind of turned. Maybe there was something about land claims in the newspapers at the time, because the conversation at the nurses' station turned towards that specifically. You know, “this is where all the money is going” and a general attitude about that. I wanted to cry for that man. I said to them, You can't imagine how this man must feel about himself to allow himself to be that neglected. It doesn't just happen overnight. You know, this is a long process of somebody who feels worthless. This man has nothing to do with land claims. Nothing. He's not going to see a dime. Like I said, they provided

the care, absolutely. But it was afterwards that you could tell there were a lot of bad feelings about the treaties and the land claims.

As alluded to by the nurse, the assumption expressed in relation to this one patient reflected a much wider range of discourses about Aboriginal rights and entitlements in Canada; comments at the nurses' station thus become part and parcel of the public debate about Aboriginal-state relations. As a microcosm of society, the hospital environment reflects the conversations that are taking place among the general public.

Some nurses spoke from personal experience as First Nations women and focused on the process by which dominant social discourses come into being. As one nurse explained:

All over the schoolyard you hear it... There is that immediate difference between them and us. It's about the things that Natives get, and then, all of a sudden, you are not on the same ground as others. And I think I went through that in high school.

Some of the non-First Nations nurses also discussed how their experiences living and working in First Nations communities made them aware of the social and historical issues shaping the lives of some patients. One nurse spoke of the perspectives she gained while working in community health:

A lot of issues came out. A lot of these women had been abused in the past and it was amazing that they had gotten the strength to decide that they were going to get an education, that they were better than just being put down all the time.

Certainly, life experiences, social positioning, ethnocultural background, educational preparation, and family upbringing will intersect to shape the kinds of knowledge and perspectives that nurses bring to their practice. The most striking feature in the findings from this study, however, was the extent to which culturalist discourses became intertwined with dominant social stereotypes about Aboriginal peoples and were expressed as fact even as they conflicted with professional discourses about egalitarianism. This illustrates the complex and sometimes contradictory ideologies that can underpin nurses' interpretive perspectives.

Discussion

It is increasingly being recognized that relating to patients on the basis of assumptions and stereotypes can jeopardize the delivery of equitable, effective services (Anderson et al., 2003; Browne & Fiske, 2001; Drevdahl, 1999; Meleis & Im, 1999; Papps & Ramsden, 1996; Reimer Kirkham, 2003; Smedley, Stith, & Nelson, 2002; Sohler, Walmsley,

Lubetkin, & Geiger, 2003). Nonetheless, a focus on the attitudes or assumptions of *individual* health-care providers overlooks the fact that attitudes and assumptions are deeply entrenched in dominant culture. Assumptions about Aboriginal peoples or any other group of people do not emerge merely from the misinformed opinions of individual nurses. The participants in this study were not espousing individually based values and assumptions, but were reflecting discourses and assumptions embedded in the dominant society and reinforced through media, institutional policies, and everyday practices (Doane & Varcoe, 2005; Furniss, 1999; Newhouse, 2004).

Nor do nurses intentionally take up these wider social discourses. On the contrary: health-care organizations “are filled with individuals who are deeply committed to their professional work, who are regarded as highly skilled practitioners, who believe themselves to be liberal human beings — and yet they unknowingly, unwittingly contribute to...inequality” (Henry et al., 2000, p. 383). Also, the professional discourses in health care that promote the ideals of egalitarianism are rooted in social and political ideologies (Browne, 2001). Liberalism, as a dominant political ideology, assumes that society is essentially fair and equitable. As Browne (2001) and Doane and Varcoe (2005) argue, liberal ideology has a profound impact on the thinking and practice of nurses and other health-care providers. Liberalism tends to steer attention in nursing away from treating racialization and other forms of inequality as relevant to health care. A recommendation arising from this study, therefore, is that strategies be adopted — in basic nursing education and in programs for practising nurses — to help nurses develop more awareness of how their interpretive perspectives are informed and shaped by wider social discourses. This is no small challenge: with few exceptions, the health and nursing literature in Canada has been silent on issues related to marginalizing and racializing practices (Reimer Kirkham, 2003; Varcoe & McCormick, in press). Nonetheless, there is a growing body of critical scholarship to draw upon, and student and practising nurses alike will benefit from engaging critically and reflexively with these issues in the context of everyday clinical practice. Only when such steps are taken will nurses develop the critical-thinking skills they need in order to question assumptions, challenge dominant discourses, and engage in critically reflexive practice.

Findings from this study also highlight the problems that can arise when narrow understandings of culture and culturalist discourses are applied to particular patients and groups. A second recommendation is that theoretical frameworks or conceptual models be developed to help nurses move beyond conceptualizing culture as primarily a matter of lifestyles, behaviours, values, or choices. In Canada there is growing

interest in one such model, that of “cultural safety”⁷ (Anderson et al., 2003; Doane & Varcoe, 2005; Downey, 2003; Reimer Kirkham et al., 2002; Smye & Browne, 2002). The central tenets of cultural safety have particular relevance in practice and education. Used as a framework for prompting critical analyses, cultural safety would encourage nurses to question popular notions of culture and cultural differences, to be more aware of the dominant social assumptions that misrepresent certain people and groups, and to reflect critically on the wider social discourses that inevitably influence nurses’ interpretive perspectives and practices. These areas of exploration could be catalysts for critically reflexive practice.

These kinds of critical analyses will require a greater nursing emphasis on the sociopolitical context of health-care encounters as well as the socio-economic and historical circumstances that shape patients’ health status, opportunities for health, and access to resources. Increasingly, university nursing programs in Canada are incorporating critical pedagogies into their curricula. These could be expanded to focus on, for example, issues of political economy, the historical process of colonization in Canada, and the role of our sociopolitical landscape in shaping inequities. However, the real challenge will lie in developing strategies for fostering critical analyses at the frontlines of health care — in the busy clinical settings in which nurses work. This will require an infusion of support for resources, time, and strategies for critically oriented continuing education activities.

Critical reflection on the discourses that shape nurses’ interpretive perspectives provides a window onto the factors that contribute to inequitable relations in health care. Only when we engage in ongoing critiques of how nursing is influenced by these discourses will we be able to contribute more fully to social justice in the realm of Aboriginal health.

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⁷ Originally developed in the New Zealand context to address persistent health and access inequities affecting Maori populations, cultural safety extends the analytical gaze well beyond notions of cultural sensitivity to power inequities, institutional forms of discrimination, and the dynamics of health-care relations in a postcolonial context (Papps & Ramsden, 1996; Ramsden, 1993, 2000, 2002).

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Author's Note

Funding for this study was provided by the Canadian Institutes of Health Research.

I would like to thank Joan Anderson, Madeleine Dion Stout, John O'Neil, and Sally Thorne for sharing their expertise. Discussions with Colleen Varcoe about issues raised in this paper were instrumental in strengthening the arguments. Many thanks to Vicki Smye, who helped me refine the final version. Thanks also to Judy Lynam, Sheryl Reimer Kirkham, and the anonymous reviewers for their valuable feedback on earlier drafts.

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