FIRST NATIONS WOMEN AND HEALTH CARE SERVICES:
THE SOCIOPOLITICAL CONTEXT OF ENCOUNTERS WITH NURSES

By

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ABSTRACT

First Nations Women and Health Care Services: 
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Health care provided to Canadian Aboriginal peoples continues to unfold against a backdrop of colonial relations. This study explored the sociopolitical and historical context of encounters between nurses and First Nations women. Using an ethnographic design and Dorothy Smith’s standpoint perspective as the method of inquiry, interactions between nurses and First Nations women were observed in a northern hospital setting. Subsequently, in-depth interviews were conducted with First Nations women, nurses, and three other health professionals (N = 35).

Incorporating aspects of postcolonial and feminist theories, this study illustrates how dominant ideologies and professional discourses intersect to organize the knowledge and attitudes that nurses bring to their practice. Three related frames of reference were examined: (a) theories of culture, (b) liberal notions of egalitarianism, and (c) popularized images and discourses of Aboriginality. In the absence of competing frames of reference, embedded assumptions about Aboriginal peoples, culture and “difference” influence the relational aspects of nurses’ work with First Nations women.

Using vignettes from the data, I explain how women’s social positioning, material circumstances, past experiences and pragmatism shape their patterns of relating with nurses, their efforts to “get along with all the nurses,” and their perceptions of nurses as “all good.” Turning their analytical gaze inward, women focused on how they were perceived by health professionals, and how they could best position themselves. To unpack the layers of subtext embedded in women’s accounts, critical consideration is given to mediating life circumstances and to particular methodological issues.
The study concludes by analyzing strategies for challenging taken-for-granted assumptions and discourses that inadvertently perpetuate colonial relations in health care. The concept of cultural safety, positioned within postcolonial perspectives, is discussed as a means of fostering critical consciousness. By directing nurses to examine historically mediated relations of power, long-standing patterns of paternalism/maternalism, and assumptions about 'race', culture and class relations, cultural safety has the potential to shift nurses’ knowledge and attitudes. Locating health care interactions within these wider historical and sociopolitical contexts can help nurses to more fully contribute to social justice in the realm of Aboriginal health.
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CHAPTER ONE
INTRODUCTION

Background to the Study

Aboriginal\(^1\) women in British Columbia (BC) and other areas of Canada continue to experience health care inequalities and barriers to accessing health care that ultimately affect their health status and the health of their children and families. A significant issue affecting equitable access and use of health services arises from the relationships that patients have with their health care providers. Interactions between patients and providers, including nurses, are not neutral; rather, they can be understood as extensions of power relations in the wider society (Anderson, Dyck & Lynam, 1997; O’Neil, 1989).

Health care encounters, and the dynamics that constitute and shape these encounters, are significant areas for study because they reflect, involve and construct broader sociopolitical and ideological relations (Crandon, 1986). Intercultural clinical encounters are particularly revealing when health care is largely provided by members of a dominant ethnocultural group to members of a predominantly subordinated group (Browne & Fiske, 2001). Health care involving Canadian Aboriginal peoples represents a case in point. A century of internal colonial\(^2\) politics, policies and practices has shaped relations between

\(^1\) Consistent with the terminology used by the Royal Commission on Aboriginal Peoples (1996b), the term Aboriginal peoples refers generally to the indigenous inhabitants of Canada including First Nations, Métis and Inuit peoples, without regard to their separate origins and identities. The Commission stresses that the term Aboriginal peoples “refers to 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. The term includes the Indian, Inuit and Métis peoples of Canada (see section 35(2) of the Constitution Act, 1982)” (p. xii). Specifically, the term First Nation replaces the term Indian and Inuit replaces the term Eskimo. The terms Indian or Eskimo, however, continue to be used in federal legislation and policy (e.g., the Indian Act), and in government reports and statistical data, particularly those generated by the federal department of Indian and Northern Affairs Canada (INAC). INAC retains the terms status or registered Indian to refer to people who have been registered by INAC as members of a First Nation under the terms of the Indian Act. When distinctions between Aboriginal groups are needed specific nomenclature is used.

\(^2\) Internal colonialism refers to “Fourth World” situations in which a minority indigenous population is encapsulated within a nation-state wherein powers and privileges are held by a colonizing majority that consciously and unconsciously subordinate the original inhabitants of the land (O’Neil, 1986; 1989).
health professionals and patients (O’Neil, 1986; Royal Commission on Aboriginal Peoples, 1996b).

The legacy of colonialism continues to be played out in health care in varying (sometimes subtle) forms. For example, institutional policies and practices that are geared toward the dominant, English-speaking, middle-class majority can inadvertently create barriers for Aboriginal peoples (Frideres, 2002). Aboriginal women, many of whom are gatekeepers to the health care system for their families and communities, face particular barriers arising from providers’ assumptions and attitudes (Browne & Fiske, 2001; Dion Stout & Kipling, 1998; Royal Commission on Aboriginal Peoples, 1996c). Disadvantages and discrimination stemming from the intersection of ‘race’, culture, class and gender create structural constraints on women’s life opportunities and shape everyday social experiences.

Despite our knowledge of the powerful influence of social determinants on health and health care, few studies in nursing have focused on Aboriginal health issues; even fewer have done so from a critical analytical perspective. This gap in our knowledge base continues to exist even though nurses provide the majority of care within Aboriginal communities and are often the only health professionals available in northern and remote regions. In part, this lack of attention to social inequities, historically mediated disadvantages, and/or racialization stems from a view of these issues as falling outside nursing’s disciplinary realm (Drevdahl, 1999; Eliason, 1999; Meleis & Im, 1999; Reimer Kirkham, 2000). These views are shaped by some of the prominent theories guiding nursing practice, particularly those which position culture as the organizing framework for understanding “differences” and inequities among various patient populations. A central concern in this dissertation is the way in which culture tends to be conceptualized as relatively static characteristics, beliefs and practices that

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3 To highlight the concept of ‘race’ as a socially constructed categorization of oppression, the term ‘race’ is set in single quotation marks.
determine behaviour, rather than as dynamic and as linked to wider sociopolitical relations. When racialized groups are involved, culture is also conflated with ‘race’, which is seen as a fixed biological category (Ahmad, 1993a). People from certain (so-called) ‘races’ are seen as having a fixed culture; these notions of ‘race’ and culture form the explanatory frameworks that nurses draw on as they attempt to interpret people’s behaviours. The concepts of ‘race’ and culture are discussed in more depth in Chapter Three.

The arguments I set out are not intended to debunk culture: knowledge of how culture shapes people’s responses to health and illness is essential to providing good nursing care. However, culture is only one dimension of people’s experiences (Anderson & Reimer Kirkham, 1998). Analyses are also needed to understand how ‘race’, racialization, and class intersect to shape people’s health and access to health care.

Unwittingly, our growing sensitivity to diversity in nursing may be contributing to marginalizing knowledge and practices (Meleis & Im, 1999). Guided by frameworks that position culture as neutral, apolitical systems of shared beliefs, meanings and practices, knowledge about patients’ cultural differences has proliferated (Reimer Kirkham et al., 2002). For example, guidelines for working in “Native American culture” have been developed with a view to assisting nurses to become more culturally sensitive (Lowe & Struthers, 2001, p. 279). Unless culture is posited as inextricably tied to historical, structural, and political inequities, however, the tendency in nursing is to overlook socially contextual and politically driven issues in health care (Meleis & Im). This is not to deny the fact of culture and cultural variations. Rather, the problem lies in conceptualizing culture as static and as the primary factor organizing health care experiences. From this analytical perspective, we tend to overlook the extent to which particular patients are “stereotyped,
rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around” (p. 96).

In general, nursing discourses\(^4\) and theories have been slow to critically examine how gender, racialization, class and history intersect to shape sociopolitical and economic realities, and health and health care experiences (Anderson, 2000b). As I have argued in a previous paper, these lines of inquiry have been constrained – particularly in the North American literature – by political and ideological\(^5\) premises which have shaped our disciplinary perspectives (Browne, 2001). For example, nursing knowledge founded on notions of liberal individualism perpetuates a view of patients as responsible for their own health and health care, despite persistent social and economic inequities known to heavily influence health and access to services. The prevailing ideology of egalitarianism in health care assumes that all people have an equal opportunity to achieve optimum health since everyone (supposedly) has equal access to services (Anderson & Reimer Kirkham, 1998). By assuming that society’s normative underpinnings are essentially egalitarian, equitable, tolerant and non-racist, we fail to look for structural constraints as critical determinants of

\(^4\) Recognizing that “discourse is notoriously difficult to define,” I draw on Shore and Wright’s (1997) definition of discourses as “configurations of ideas which provide the threads from which ideologies are woven” (p. 18), and on Seidel and Vidal (1997), who view discourses as patterns of thinking that overlap and reinforce each other while closing off alternate avenues of thinking. Of central concern is who has the ‘power to define’ given that “dominant discourses work by setting up the terms of reference and by disallowing or marginalizing alternatives” (Shore & Wright, p. 18).

\(^5\) Conceptualizations of ideology are diverse and shifting (Browne, 2001). Dorothy Smith (1987) has advanced the notion of ideology as those ideas and values which organize and maintain the relations of ruling in our society, and as the medium through which our ideas, practices and social relations are organized and operate in everyday life. Stuart Hall (1986/1996c) views ideology as the claim of particular sociocultural practices to represent reality and positions of dominance. As Thorne, Reimer Kirkham and Henderson (1999) note, “When we refer to social structures as ideological, we invoke an analytical perspective of how certain ideas and beliefs get put together in order to maintain or reinforce privilege” (p. 123). What is clear among all definitions is that ideologies advance value-laden claims about human nature, freedom, science and social justice, among other politically contentious issues (Love, 1998). Given these defining characteristics, the consensus among critically oriented scholars is that ideology is so deeply rooted in modern culture as to be almost impossible or at least extremely difficult, to recognize, acknowledge, or escape (Heywood 1992).
health and illness. From this ideological viewpoint, nursing tends to mistake racism for ethnocentrism, ill health as lifestyle choice, and lack of participation in health programs as stemming from cultural differences (Culley, 1996). Consequently, our ability to adequately and critically address these politically laden issues in nursing theory and practice has been limited.

The tendency for nurses (and doctors) to bracket out the sociopolitical context of health care encounters also stems from their professional socialization and predominantly middle-class values (O’Neil, 1989). When Aboriginal patients are involved, we fail to consider institutional and colonial relationships in health care, and ignore the fact that “medical institutions are powerful symbols of a recent colonial past” (p. 341). In this context, the potential for nurses and patients to misinterpret seemingly innocuous behaviours is high.

**Central Problem**

Health care provided to Aboriginal peoples continues to unfold against a backdrop of internal colonial relations. Despite the extent of contact between nurses and First Nations patients in clinical settings, few studies have critically examined how nurses and First Nations women relate to each other and the factors shaping these relations. The central problematic addressed in this study, therefore, is the sociopolitical and historical context of relations between nurses and First Nations women.

Informed by prior research, I build on perspectives gained from studies involving Cree-Ojibway patients in northern Manitoba, and Carrier First Nations women in north-central BC (Browne, 1995, 1997; Browne & Fiske, 2001; Browne, Fiske & Thomas, 2000). This dissertation expands on this previous work by developing additional angles of analysis.
from which to examine health care encounters and the dynamics of relations shaping these encounters.

**Research Objectives**

The overarching purpose of the dissertation is to more fully understand: (a) the sociopolitical and historical contexts of relations between nurses and First Nations women, and (b) the extent to which these relations shape routine interactions between nurses and women. Using selected dimensions of postcolonial and feminist theories, and Smith’s (1992) standpoint perspective as the method of inquiry, patterns of interactions between nurses and First Nations women in a northern hospital setting were critically examined. The specific objectives of the research were to:

1. examine the patterns of interaction between nurses and First Nations women in a clinical context within a northern health care setting in BC,
2. analyze the experiences of nurses and First Nations women within wider institutional and sociopolitical contexts to understand how these contexts shape relations between nurses and First Nations women, and
3. generate recommendations concerning nursing’s role in contributing to equitable health care involving First Nations women.

To address these objectives, interactions between nurses and First Nations women were observed on various units within a northern hospital setting. In-depth interviews with women and nurses were then conducted to elicit how they understand and experience their interactions with each other. Additional contextual information was provided through interviews with the hospital’s Aboriginal Support Worker and a health care administrator. Drawing on Smith’s (1992) standpoint methodology, the experiences and perspectives of
women and nurses were analyzed within their wider contexts to explicate how historical, social and political issues organize everyday interactions between nurses and First Nations women.

**Organization of the Thesis**

The present chapter has provided an introduction to the research topic and specific objectives. The remainder of the dissertation is organized around a central line of argument, which illustrates how dominant ideologies and professional discourses intersect to organize the attitudes and knowledge that nurses bring to their practice with First Nations women. First Nations women, variously positioned within historical and current power relations, also draw on knowledge and assumptions about health care providers as they interact with nurses and navigate the health care system.

Chapter Two addresses the historical context of Aboriginal-state relations, particularly as they have influenced the health and social status of Aboriginal women in Canada. I examine how colonial ideologies and practices from the past persist in shaping the collective consciousness of the dominant culture in this country, and influence relationships between Aboriginal and non-Aboriginal peoples. This provides the backdrop against which to examine the dynamics of relations between nurses and First Nations women.

Chapter Three outlines the theoretical foundations of this work. Positioned within an emerging body of nursing scholarship that draws on postcolonial feminist perspectives, I delineate the theoretical perspectives that influence my understanding of Canada’s colonial history, gendered relations, culturalism, difference, and racialization. These emerge as key analytical constructs in this study. I also draw on the perspectives of Aboriginal scholars who have critiqued these theoretical perspectives in terms of their relevance and applicability.
Within this theoretical orientation, Chapter Four presents the research methodology. After describing the central tenets of Smith’s standpoint perspective as the method of inquiry framing the research implementation, I discuss the procedures used to sample participants, collect and analyze the data, and maintain scientific rigour. This chapter also includes a reflexive analysis of how my social and professional positioning has shaped all stages of the research process.

Chapters Five to Eight represent the empirical findings of this research. Chapter Five focuses on the nurses’ perspectives. Specifically, I examine how three related frames of reference shape nurses’ understanding of and attitudes toward Aboriginal patients. These include (a) theories of culture, (b) liberal notions of egalitarianism, and (c) popularized images and discourses of Aboriginality. In Chapter Six, I focus more pointedly on the dynamics of nurse-patient interactions and how nurses’ understandings of Aboriginal peoples shape the tenor of their interactions. Using examples from interview and observational data, I examine how assumptions about Aboriginal peoples, culture and difference are interwoven and reproduced in routine interactions to organize the relational aspects of nurses’ work.

In Chapter Seven, I shift the analysis to women’s interpretations of their hospital experiences and interactions with nurses. Using vignettes from the data, I show how women’s social positioning, material circumstances, past experiences and sense of personal agency influence their patterns of relating with nurses, their efforts to “get along with all the nurses,” and their perceptions of nurses as “all good.” These data highlight the importance of analyzing health care interactions within wider fields of historically mediated power relations.
In Chapter Eight, I shift the attention back onto the nurses, and in particular, onto the institutional context of nurses’ work. Here I examine how racializing discourses about Aboriginality – this time referenced in relation to Aboriginal nurses – are taken up as normal, acceptable conversations, contributing to a work environment that remains permissive of dominant ideological projections of Aboriginal peoples. In Chapter Nine, the final chapter, I reconsider the findings in light of the theoretical perspectives informing this research. In the process, I put forward recommendations for fostering the development of critical perspectives and critical consciousness in nursing as strategies for advancing the provision of health care involving First Nations patients.

As the dissertation unfolds, I wish to draw the readers’ attention to the problems inherent in applying labels to the diverse groups who comprise Aboriginal peoples in Canada. Positioned within definitional and divisive discourses, these labels have varied historically and will continue to shift. In recognition of the complex issues of representation and identity embedded in labels and nomenclature, I continue to take guidance from the Royal Commission on Aboriginal Peoples (1996b) as articulated in the first footnote on page one. I use the term Aboriginal peoples to refer generally to the diverse groups within Canada. First Nations is used more specifically to refer to the participants in this study who identified as First Nations, and to refer to particular First Nations within BC and other areas of Canada.
CHAPTER TWO

REVIEW OF EXISTING KNOWLEDGE: HISTORICAL AND CURRENT PERSPECTIVES

Introduction

In this chapter, the literature is reviewed to provide a historical and current context in which to examine the dynamics of relations between nurses and First Nations women. I begin by drawing on the works of Aboriginal and non-Aboriginal scholars who have written about the impact of colonization on the lives and wellbeing of Aboriginal peoples in general and Aboriginal women in particular. These perspectives illustrate how colonial ideologies and practices from the past continue to permeate the collective consciousness of the dominant culture.

Next, I examine the historical development of relations of paternalism/maternalism, mistrust and dependency in health care involving Aboriginal peoples in Canada. Examining continuities between the past and the present helps to explain why health care institutions remain symbolic of past colonial relations (O'Neil, 1989). As I argue in subsequent chapters, understanding the historical and structural contexts in which health care is delivered is critical to understanding the complexities of interactions involving nurses and First Nations women.

6 I use the term structural to refer to those fundamental structures in society – the state, the polity's social and economic status, local and global political economies, globalization and racialization, and dominant institutions including health, legal, educational and government systems – that define, determine and reproduce unequal power relations, racialization, class, and patriarchy as a basis for social relations (Browne, 2001). These "structural forces and social relations... impinge upon and determine the range of choices available to social subjects" (Roman & Apple, 1990, p. 42). To say that social and economic inequities, power differentials, racialization and sexism are structural is to suggest that they exist in the institutions and social practices of our society and cannot be explained as merely situational or as arising from the intentions of individuals (Weedon, 1997). These structures are viewed as constraining the interests of some members of society while promoting the interests of others (typically members of the dominant society). In examining structural constraints, inequities based on race, class, gender, power differentials, sexual orientation and age become the primary analytical interests within larger health, social, political and economic analyses (Roman & Apple).
To situate the health concerns of Aboriginal women in a wider social context, the chapter proceeds with a brief overview of major health and social status indicators. Engaging critically with epidemiological discourses, I also examine epidemiological profiles as systems of surveillance that can inadvertently perpetuate mis/representations of Aboriginal women (O’Neil, Reading & Leader, 1998).

I then provide an analysis of the current political backdrop against which Aboriginal-state relations are continually negotiated and renegotiated. The 2002 “treaty referendum” in BC, for example, has contributed to rising tensions between Aboriginal and non-Aboriginal sectors. Land claims and modern day treaty negotiations – particularly in BC – bring the dynamics of strained colonial relations into sharp focus. Interactions between nurses and First Nations women thus unfold within a particular political context.

The focus of the chapter then shifts to examine research informing the study of health care interactions involving Aboriginal peoples. Incorporating perspectives from the social sciences, I focus on the complexities of health care interactions when gender, culture, ‘race’ and class are considered. Although few empirical studies have focused specifically on nurses’ relations with First Nations patients, related research emphasizes the importance of situating the micropolitics of health care encounters within a broader sociopolitical and historical context.

**Locating Colonial Relations in a Historical Context**

Colonialism continues to subjugate Aboriginal women in numerous ways that are distinct from the disadvantages and oppression experienced by women of the dominant society (Fiske, 2000a). As Emma LaRocque (1996), a Métis scholar, writes, the effects of
Colonization\(^7\) have been far-reaching and have affected men and women in different ways. LaRocque explains:

Colonization has taken its toll on all Native peoples, but perhaps it has taken its greatest toll on women...Racism and sexism found in the colonial process have served to dramatically undermine the place and value of women in Aboriginal cultures, leaving us vulnerable both within and outside of our communities....Native women continue to experience discrimination through the Indian Act, inadequate representation in Native and mainstream organizations, lack of official presentations in self-government discussions, under-and/or unequal employment, and ghettoization of the educated Native woman, for example. The tentacles of colonization are not only extant today, but may also be multiplying and encircling Native peoples in ever-tighter grips of landlessness and marginalization, hence, of anger, anomie, and violence, in which women are the more obvious victims. (p. 11-12)

The systematic subjugation of women has its origins in the colonial laws and policies concerning Aboriginal peoples that were consolidated in 1876 in the Indian Act. This framework, premised on the paternalistic guise of assisting Indians as wards of the state, was intended not to assist but to civilize and eliminate Indians (Fiske, 1995; Joseph, 1991). Ultimately, the goal of the Indian Act was to govern Indians in Canada and "to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and

\(^7\) In the Canadian context, LaRocque (1993) defines colonization as "the process of encroachment and subsequent subjugation of aboriginal peoples since the arrival of Europeans. From the Aboriginal perspective, it refers to the loss of lands, resources, and self-direction and to the severe disturbance of cultural ways and values" (p. 73). Kelm (1998) also emphasizes that the colonization process does not operate on a single trajectory, but rather, should be understood as "diffuse, dialectical, and subject to competing positions both from within the society of the colonizers and from the colonized" (p. xviii).
there is no Indian question and no Indian Department” (cited in Manitoba Public Inquiry, 1991, p. 73).

The drive to achieve assimilation was pursued on many different levels. For example, classifications of Aboriginal peoples were legislated for the purposes of governing aspects of everyday life: Aboriginal lands were appropriated, Aboriginal peoples were marginalized on reserve lands, cultural spiritual practices were outlawed, and indoctrination into the dominant culture was attempted by force through church or state-run residential schools (Armitage, 1995). While it has been recognized that state\textsuperscript{8} policy toward Aboriginal peoples in Canada stands as the most significant factor in explaining the relationship between Aboriginal and non-Aboriginal Canadians, Fiske (1995) argues that “the paternalistic relationship between the state and Indian women is of particular salience” in understanding women’s social position (p. 4).

LaRocque (1996) argues, “Racism and sexism together result in powerful personal and structural expressions in any society, but they are clearly exacerbated under colonial conditions” (p. 15). This is exemplified in the case of Aboriginal women\textsuperscript{9}, who, under the Indian Act, continue to be assigned fewer fundamental rights than men (Fiske, 1993, 1995; Stevenson, 1999). A full discussion of these legislated, gendered discrepancies can be found in the Royal Commission of Aboriginal Peoples (1996c) and in other key readings (e.g.,

\textsuperscript{8} “State” is used as Lee and Cardinal (1998) define it to refer to: “a complex formation including all levels of government, institutions, and agencies, policies, procedures, and regulations as well as state agents who initiate, implement, manage, and represent the state...[It] is not meant to imply a monolithic cohesive entity that acts with logic and coherence. The state is also historically emergent, changing, contested, and a site of struggle” (p. 238).

\textsuperscript{9} The heterogeneity among Aboriginal communities notwithstanding, many Aboriginal societies were matrilineal, with women holding political power, owning substantial property and exercising dominion over subsistence production (Fiske, 1993, 2000b; Royal Commission on Aboriginal Peoples, 1996b; Voyageur, 1996).
Stevenson, 1999; Fiske, 1995; Monture, 1995). Here, I highlight selected policies to indicate the extent to which state policies controlled, manipulated and constrained Aboriginal women's gendered, social and political relations within and outside Aboriginal communities.

One of the most oppressive and controversial was the enactment of patriarchal state ideology, which, until the 1985 amendments to the Indian Act\(^\text{10}\), stripped women and their children of their status upon marrying non-Indian or non-status Indian men (Stevenson, 1999). The effect was to dispossess women, their children and grandchildren of whatever inherent protections and rights the Indian Act offered (Fiske, 1993, 1995). For example, women and their children could not reside on reserve lands, receive payment of any benefits resulting from treaties, or be buried in a reserve cemetery. Even when married to status Indian men, women were excluded from holding parcels of land under the state-defined system. As per Indian Act amendments in 1927, widows could not inherit property unless there was a male heir or until the Indian Agent decreed the widows to be "of good moral character" (Fiske, 1993, p. 20). The denial of property rights\(^\text{11}\) directly affected women's capacity to support themselves and their families, exacerbating their economic marginalization and the development of welfare colonialism. Women who retained their

\(^{10}\) These amendments, known commonly as Bill C-31, allowed women who had previously lost their status to regain status. As many scholars and Aboriginal organizations have pointed out, however, Bill C-31 did not eradicate gender discrimination (Fiske, 1993, 1995; Joseph, 1991; Manitoba Public Inquiry, 1991; Monture, 1995; Royal Commission on Aboriginal Peoples, 1996c; Turpel, 1993). As Fiske (1993) explains, "reinstatement of Indian status remains dependent upon male lineage" (p. 16). Additionally, to pass on status to their children, status women giving birth "out of wedlock" must submit an affidavit of paternity before their children can be granted status: "Such state intrusion into a mother's relationship to her children and to their father is unknown to other Canadian residents" (p. 23). State-defined criteria for who can and cannot be granted status, "have brought greater state surveillance of women's daily lives and sexual relations" (p. 23). Further details concerning the controversies surrounding Bill C-31 can be found in the readings referenced above.

\(^{11}\) Contradictions and deficiencies in current federal and provincial laws concerning marital property and divorce laws continue to disadvantage women (Fiske, 1993). Today, provincial laws, which cannot be enacted on reserve, are subject to local-level arbitrary ruling. Appeals to revise the Indian Act to allow for the same marital property rights as other Canadian women have been rejected. Consequently, Aboriginal women continue to be "denied the security of housing and community residency essential to family well being" (p. 23).
status, however, were not permitted to participate in political affairs or hold elected positions on community councils until amendments to the Indian Act in 1951 (Fiske, 1990). Status First Nations women, like men, were not permitted to vote in federal elections until 1960 despite the fact that “Aboriginal people were among the most intensively governed sectors of Canadian society” (Furniss, 1999, p. 44).

The violations enforced on Aboriginal women were compounded as their children were forced through mandatory legislation to attend residential schools (Canadian Panel on Violence Against Women, 1993):

The residential school system cut to the very soul of Aboriginal women by stealing their most valued and vital roles of mother and grandmother, along with their children....The residential school era marked a turning point for Aboriginal women in Canada....Aboriginal women now struggled daily for survival, amid the turmoil of violence and abuse that had become a new reality. (p. 146)

The intergenerational consequences of residential schooling are now well known (Fiske, 1996a; Royal Commission on Aboriginal Peoples, 1996a). Nonetheless, residential schools failed in their attempt to assimilate Aboriginal peoples. As Fiske (1996a) has carefully documented in the case of the Carrier people of north central BC, many women – in spite of the harsh treatment – used new skills and knowledge acquired in residential schools to advance their social, economic and political roles within and outside their communities. For these women, residential schools paradoxically and unintentionally provided a foundation upon which to build structures of resistance.

12 Status First Nations people in BC were granted the right to vote in provincial elections in 1949 (Furniss, 1999).

13 The first residential school in BC opened in 1861 and was also the last to close in 1984 (Ward, 2001).
Colonizing Images of Aboriginal Women

To explain how the subjugation of Aboriginal women was rationalized and implemented, scholars are paying special attention to how colonial images were used by the state and its agents to manipulate public perceptions. Winona Stevenson (1999), a Native Studies professor, writes:

The manner in which colonial agents represented Aboriginal Peoples were [sic] primarily the result of their need to convince themselves and other members of their societies that their agendas were righteous. Imaging, through visual and other forms of representation, also served, and still serves, those in power to rationalize or explain socio-economic inequities. (p. 49)

Historically, the ideological rationale for the subjugation of women was fueled by missionaries and government agents who provided the state with misinformation disparaging the morality of Aboriginal women, and their skills as mothers and homemakers (Stevenson, 1999). Images of Aboriginal women as dissolute, neglectful and irresponsible were given as rationale for the extreme levels of poverty and ill health in First Nations communities, creating misrepresentations that both “blamed First Nations women for their lot in life and justified state intervention” (p. 66). Constructed as either noble “princesses” or “squaw drudges,” these contradictory colonial images of Aboriginal women became unambiguously negative over time (p. 57).

Paula Gunn Allen (1995), a Native American scholar, writes about the significance of colonial mis/representations of Aboriginal women: “Image casting and image control constitute the central processes that American Indian women must come to terms with, for on that control rests our sense of self, our claim to a past and to a future that we define and that
we build” (p. 35). In the Canadian context, Fiske (1993) has demonstrated how enduring images of Aboriginal women as irresponsible and incapable have contributed to the “inferiorization of Aboriginal motherhood” (p. 20). The treatment of mothers by child welfare authorities represents a case in point. Referred to as the sixties scoop, thousands of Aboriginal children were deemed to be in need of protection from their mothers who were themselves constructed and treated as child-like, irresponsible and incapable (Fiske; Manitoba Public Inquiry, 1991; Canadian Panel on Violence Against Women, 1993). Today, although control of child welfare services has been transferred to many First Nations, the socioeconomic conditions that place women and children at risk – for example, lack of access to secure housing and economic opportunities – have not been confronted and remedied.

More recently, public awareness campaigns portraying fetal alcohol syndrome as an Aboriginal health problem have contributed to the inferiorization of Aboriginal women (Rutman, Callahan, Lundquist, Jackson & Field, 2000; Tait, 2000a, 2002b). National news coverage of the ‘G’ case14 in 1996 to 1997, for example, reinforced public stereotypes of Aboriginal women as irresponsible, negligent and substance abusers (Tait, 2000b). As Tait writes, “In the end the image of ‘G’, carrying the future of Aboriginal people in her toxic womb, was firmly implanted in the collective imagination of Canadian society” (p. 105).

Negative images of Aboriginal women are not merely symbolic. As LaRocque (1993) argues, these images have contributed to the ongoing physical and sexual abuse of Aboriginal women in contemporary society:

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14 This case involved a 22-year-old pregnant woman in Winnipeg who fought against court-ordered addiction treatment, which ended in the Supreme Court of Canada (Tait, 2000b).
A complex of white North American cultural myths, as expressed in literature and popular culture, has perpetuated racist/sexist stereotypes about Aboriginal women. A direct relationship between racist/sexist stereotypes and violence can be seen, for example, in the dehumanizing portrayal of Aboriginal women as "squaws," which renders all aboriginal female persons vulnerable to physical, verbal and sexual violence. (p. 74)

LaRocque and others (e.g., McConney, 1999) have linked popularized images of Aboriginal women as "lustful, immoral, unfeeling and dirty" (LaRocque cited in Manitoba Public Inquiry, 1991, p. 479) with the ongoing brutalization of Aboriginal women. The case of Robert William Pickton, charged with murdering at least 15 women in Vancouver, many of whom were Aboriginal (The Missing Women, 2003), highlights the brutality that can result from commodification of Aboriginal women as dispensable.

Extending her analysis, LaRocque (1996) argues that negative images and stereotypes "have had a profound impact on the self-images of Native men and women, respectively, and on their relationships with each other" (p. 12). She frames the alarmingly high rates of domestic and sexual violence experienced by Aboriginal women and children as "one of the most problematic legacies of long-term colonization" (1993, p. 74). Today, domestic, sexual and other forms of violence continue to be cited as one of the most pressing issues facing communities (Aboriginal Nurses Association, 2001). Recognizing the pervasiveness of violence, Mary Ellen Turpel (1993), an Aboriginal lawyer and scholar, has reframed the term "culture of violence" to include the destructive effects of colonization perpetrated by the Canadian state on Aboriginal women's cultural identity, self-concept, and social roles (p. 183). In so doing, the broader historical and sociopolitical context of violence is emphasized.
One of the pressing concerns raised by LaRocque (1993) concerns the “popularity of offering ‘cultural differences’ as explanation for sexual violence” (p. 76). Here, LaRocque is referring to the ease with which institutions\textsuperscript{15} and agents of the dominant culture – for example, the media, the justice system, the police and the social service sector – erroneously equate violence and sexual abuse as Aboriginal cultural traits. LaRocque writes:

Erroneous cultural explanations have created enormous confusion in many people and on many issues. Besides the problem of typecasting Aboriginal cultures into a static list of “traits,” 500 years of colonial history are being whitewashed into mere “cultural differences.” Social conditions arising from societal negligence and policies have been explained away as ‘cultural’. (p. 76)

Negative images created in the past, therefore, have an enduring quality today as re/presentations of gendered stereotypes continue to “foster dangerous attitudes that affect human relations and inform institutional ideology” (Acoose, 1995, p. 40).

Although many of the discriminatory sections of the Indian Act were eventually repealed, it was “not in time to stay the internalization of many European patriarchal notions and practices” (Stevenson, 1999, p. 74). Nonetheless, colonial assimilation strategies were ultimately unsuccessful. Ongoing healing, revitalization of traditional knowledge and practices, and gains in the area of self-determination are attestations of strength, resiliency, and the capacity for resistance among societies carrying the burden of colonization, racialization, sexism and oppression (Fiske, 2000a).

\textsuperscript{15} I am referring to those systems that are foundational to the Canadian state including justice, health care, educational, governmental, and corporate systems. My conceptualization of institutions is also influenced by Smith’s (1987) use of the term to “identify a complex of relations forming part of the ruling apparatus, organized around a distinctive function” (p.160). As she writes, “Characteristically, state agencies are tied in with professional forms of organization” and might be imagined as “nodes or knots” in the relations of the dominant culture (p. 160).
Historical Context of Paternalism in Health Care

The provision of health care services to Aboriginal peoples was part and parcel of the process of colonization, and was instrumental in cultivating disempowerment and dependency (Kelm, 1998). Dependency is used in this context to describe conditions in which First Nations’ economies, governing structures, and local level institutions have been subjugated by the development and expansion of the dominant society’s economy and institutions (Santos cited in Gagne, 1994). In this context, dependency is situated well beyond liberalist notions of personal responsibility and choice.

The history of dependence on fledgling health services can be traced to the infectious epidemics that ravaged Aboriginal communities during periods of contact with non-Aboriginal traders, explorers and settlers (Royal Commission on Aboriginal Peoples, 1996a; Waldram, Herring & Young, 1995). Simultaneously, forced economic dependence, appropriation of traditional lands, confinement to reserves, prohibitions placed on subsistence hunting, and marginalization from the wage economy resulted in endemic poverty (Fiske, 1992; Ponting, 1997; Waldram et al., 1995). The loss of power and control over most aspects of community life, and the profound decline in health status, paved the way for dependency on health care and other forms of government aid.

In response to devastating societal changes that threatened their existence, Aboriginal leaders negotiated agreements and treaties with the Euro-Canadian state aimed at ensuring their survival (Royal Commission on Aboriginal Peoples, 1996a). In exchange for these agreements, limited food rations and medical resources were provided. As part of the wider colonial project, however, medical resources were often used as commodities that could be
exchanged for economic exploitation and religious conversion\(^6\) (O’Neil & Kaufert, 1990). Whether federal health services were considered an Aboriginal right\(^7\) or a matter of policy\(^8\) continues to be debated\(^9\). Government officials and their employees were clear, however, that health services were “not just to improve Aboriginal quality of life, but to justify, legitimate, and sustain Canada’s internal colonial relations with the First Nations….Here notions of racial superiority and the ‘white man’s burden’, assimilative goals, and the fear of interracial pathological contagion merged to set the parameters of federal Indian health policy” (Kelm, 1998, p. 100).

In the first half of the 20\(^{th}\) century, emphasis in health care was on medical relief provided in the name of humanitarianism (T.K. Young, 1984). Inextricably linked with notions of racial superiority and the right to civilize Aboriginal peoples, health practitioners and the perspectives they imposed provided the practices and symbols for “humanitarian domination” (Kelm, 1998, p. 102). For wards of the nation, health services were provided in a spirit of “benign neglect” and “benevolent paternalism” (T.K. Young, 1984, p. 260).

In the spirit of humanitarianism, residential schooling was enforced as a means of preserving the health of Aboriginal children who required protection from their supposedly “negligent and ignorant parents” (Kelm, 1998, p. 62). Kelm documents the efforts of

\(^{16}\) Aboriginal medicine was not superseded by Western approaches; rather, a state of medical pluralism developed in which Aboriginal peoples drew on both Aboriginal and Western medicine to cope with new diseases (Kelm, 1998).

\(^{17}\) The treaty right to health care is usually referred to as the medicine chest clause in Treaty 6, signed with the Plains Cree in 1876 (O’Neil et al., 1999).

\(^{18}\) The official position of the First Nations and Inuit Health Branch of Health Canada, the federal governmental branch responsible for status First Nations and Inuit health, is that health services are a matter of policy, not an inherent right (First Nations and Inuit Health Branch, 2003; Health Canada, 1995).

\(^{19}\) Given the different motives surrounding the negotiations of treaties and their medical services provisions (i.e., for the survival of Aboriginal communities versus the appropriation of lands and resources for the Euro-Canadian state), it is not surprising that different interpretations have been ascribed to fiduciary obligations regarding health care (Royal Commission on Aboriginal Peoples, 1996b).
federally employed public health nurses who argued that high infant mortality rates in the Yukon in the 1950s were caused by Aboriginal mothers who like "errant children" failed to follow their edicts for cleanliness (p. 62). Viewed as a means of saving a 'race' "dying from maternal neglect" (p. 61), residential school students were taught public health nursing principles in an effort to convert their mothers and families to a "healthy Christian lifestyle" (p. 62). Tragically, despite the rhetoric of Christian cleanliness, records indicate that death rates from tuberculosis (TB) and other infectious diseases were extremely high as a direct result of overcrowding and poor nourishment in residential schools.

It was not until the 1930s that the Canadian state began to develop a system of primary care clinics, public health nursing programs and designated regional hospitals in or near Aboriginal communities (T.K. Young, 1984). Initiated primarily in response to the threat that infectious epidemics in Aboriginal communities posed to neighbouring white communities, these services were founded on a paternalistic and authoritarian model of health care delivery which continued the process of demoralization and growing dependency (Kelm, 1998; O'Neil, 1986). The enforced quarantine of infected individuals in Indian hospitals separated people from their home communities, exacerbated the social damage already incurred as a result of epidemics, and fostered further dependency on colonial medicine. Implicit in this approach to treatment, and in the context of growing desperation, was the message that treatment of disease was entirely in the hands of the colonial power (O'Neil & Kaufert, 1990).

Western health services also supported the systems of internal colonialism by establishing the superiority of Euro-Canadian doctors and nurses (Kelm, 1998). Positions of superiority and inferiority were reinforced in various ways; as with most physicians' offices
in BC prior to the 1950s, two entrances existed, one for Aboriginal peoples and another for non-Aboriginal patients. Today, many Aboriginal peoples remember how they or their family members were hospitalized in segregated wards (Moran, 1988).

Building on long-standing notions of Aboriginal women as irresponsible mothers, field matrons (lay women with health care training) and registered nurses exercised their superiority and authority in a number of ways. In the 1940s, some made it their practice to submit the names of children whose home situations were deemed unhealthy and from which they recommended the children’s immediate removal (Kelm, 1998). Others used legal control and jail sentencing to enforce health regulations. Kelm documents the activities of some who doggedly tracked down women suffering from venereal disease only to jail them “to remove them as health risks” (p. 150). These practices laid the foundation for health care encounters that were very often “clouded by suspicion, misunderstanding, resentment and racism” (Royal Commission on Aboriginal Peoples, 1996b, p. 114).

Although the expansion of health services in Aboriginal communities post-WWII (and the discovery of TB antibiotics) helped to reduce the morbidity and mortality rates from infectious diseases, major discrepancies in health status remained (T.K. Young, 1984). These health problems stemmed from extreme poverty, lack of clean water and sewage systems, inadequate nutrition and housing, and unemployment. Infectious diseases, while still endemic in the 1960s, were eventually overtaken by the “social pathologies”: mental health conditions (e.g., depression, anxiety, and suicide), high infant mortality rates, and social problems (e.g., alcoholism and family violence) (T.K. Young, 1994, p. 176). Consistent with biomedical epistemological assumptions and approaches to health care, health authorities viewed these conditions as medical problems that could be treated according to the prevailing medical
model (O'Neil, 1986). Thus emerged the process of medicalizing social problems as biologically-based diseases or lifestyle issues, rather than as conditions arising from impoverished social and economic circumstances. As health services have expanded in Aboriginal communities, medicalization has persisted as a central ideology underlying health services provision (O'Neil, 1986).

Today, a large proportion of First Nations communities have entered into Health Transfer agreements officially launched by Health Canada in 1986. For many communities and First Nations, control of federally sponsored health services represents a critical step in the move toward self-government (O'Neil, Lemchuk-Favel, Allard & Postl, 1999). Transfer of services, however, applies only to administrative control and management of existing federal services, and not to absolute control of planning, implementing, evaluating or expanding services. Although many communities have undertaken transfer arrangements, the overall process has been widely criticized as an attempt to off-load fiduciary responsibilities onto Aboriginal communities without adequate human or material resources (Culhane Speck, 1989; Gregory, Russell, Hurd, Tyance & Sloan, 1992; O'Neil et al., 1999; Scott, 1990). Constraints on transfer arrangements limit the extent to which communities can address the wider social determinants of health. Moreover, by reinforcing the dominance of the medical model as the organizing approach to services, the transfer process does little to disrupt relations of power in health care (Gregory et al.). Although overall health status has improved, communities continue to struggle as they attempt to address persistent health inequities stemming from wider social issues.

20 As of March 31, 2001, 276 (46%) of the 599 First Nations communities across Canada have signed Health Services Transfer Agreements (Health Canada, 2001).
Contemporary Determinants of Aboriginal Women's Health

Current health and social status indicators for Canadian Aboriginal women are well documented and demonstrate major discrepancies in comparison to other Canadian women (Dion Stout & Kipling, 1998). For example, in BC, life expectancy for status women between 1991-1995 was 6.7 years less than other women (BC Provincial Health Officer, 2002). Age standardized mortality rates from all causes for status Indians between 1991-1999 was 1.7 times higher than for other BC residents. Infant mortality rates, a powerful barometer of social conditions, remained 2.2 times higher for status Indian babies than for other babies between 1991-1999. Welfare colonialism has resulted in high unemployment rates and dependency upon meagre social assistance payments (Fiske, 1992). In urban centres in 1991, 80% to 90% of Aboriginal female-led households were found to exist below the poverty line (Royal Commission on Aboriginal Peoples, 1996c). More recent data from western Canada found that approximately 40% of urban Aboriginal peoples live on incomes less than $10,000 per year (Simard, 2001). In reserve communities, women’s economic hardships are compounded by a persistent lack of adequate housing. The housing crisis on reserves has been further exacerbated by the influx of women (and their families) whose status was reinstated through Bill C-31 (Joseph, 1991). Adding to social and economic strain, women are often placed at the bottom of long waiting lists for properly furbished houses as communities struggle (or may be unwilling) to accommodate those returning to their communities of origin (Voyageur, 1996).

The links between poverty and ill health are now well established and widely accepted (Evans, Barer & Marmor, 1994; Krieger, Rowley, Herman, Avery & Phillips,
1993), and are evident within First Nations populations in relation to high rates of smoking\textsuperscript{21}, injuries and accidents and HIV/AIDS (BC Provincial Health Officer, 2002; First Nations and Inuit Health Survey, 1999). The synergistic effect of unemployment and poverty contributes to the proliferation of unmet human needs, social pathologies, and high rates of family violence (Dion Stout, 1997; T.K. Young, 1994). Poverty undermines self-esteem and self-worth, making women more vulnerable to violence, alcohol and substance abuse, and the risks associated with each (Aboriginal Nurses Association, 1996; Dion Stout, 1996, 1997). The current crisis caused by extremely high rates of HIV among Aboriginal women\textsuperscript{22} is one of the most devastating manifestations of the cumulative effects of poverty, dispossession, powerlessness and despair (Spittal & Schechter, 2001).

Disempowerment has received little attention as a determinant of health despite evidence indicating that lack of power and control erodes people's sense of wellbeing (Ponting, 1997). Health effects may be most obviously manifested in the area of mental health as depression, suicide\textsuperscript{23}, anxiety and substance abuse (Royal Commission on Aboriginal Peoples, 1996b). Stemming from years of oppression, welfare colonialism,

\textsuperscript{21} Data from the First Nations and Inuit Regional Health Survey (1999) indicate that 62% of people who self-identified as First Nations smoked tobacco compared to 31% of other Canadians. These rates were up to 74% among young adults age 20-24.

\textsuperscript{22} According to a Health Canada statistics, HIV infection among Aboriginal populations has increased 91% from 1996 to 1999 (AIDS Among Aboriginals, 2001). The epidemiology of HIV differs significantly from non-Aboriginal populations, particularly in relation to women's rates. Nationally during 1998-2000, women represented nearly half (45.6%) of all positive HIV test reports among Aboriginal persons, however females represented only 19.8% of reports for non-Aboriginal persons (Health Canada, 2002). In BC, between 1996 and 2001, Aboriginal women comprised approximately 43% of all new infections in the Aboriginal population, while non-Aboriginal women comprised only 18% of total non-Aboriginal cases (BC Provincial Health Officer, 2002).

\textsuperscript{23} As reported by the Assembly of First Nations (2002), "Statistics show that First Nations youth (35% less than 15 years of age) are committing suicide at extremely high rates compared to the overall Canadian population – 8 times higher for First Nations females, and 5 times higher for First Nations males. Currently, there are no federal resources available to address suicide prevention among First Nations."
poverty and violence, these social and health inequities cannot be glossed over as lifestyle, behaviour or cultural issues; rather, they are manifestations of the complex interplay of historical, social, political and economic determinants influencing health status and access to equitable health care.

**Epidemiological Constructions of Health and Illness**

Epidemiological data that describe the health of First Nations populations are valuable in alerting communities, the health service sector, and policy makers to pressing health and illness trends. Clearly, epidemiological summaries are essential in justifying community and government driven requests for programs and funding. At the same time, epidemiological studies represent “systems of surveillance,” which have been instrumental in shaping public understandings of Aboriginal peoples and communities (O’Neil, 1993, p. 34).

As O’Neil et al. (1998) explain, there are dangers in profiling epidemiological constructions of health and illness trends. The risk lies in contributing to “an understanding of Aboriginal society that reinforces unequal power relationships; in other words, an image of sick, disorganized communities can be used to justify paternalism and dependence” (p. 230). Epidemiological constructions of risk factors for cervical cancer among Aboriginal women provide a case in point\(^\text{24}\). Accurate documentation of high rates of cervical cancer mortality\(^\text{25}\) have been required to fuel public health efforts to detect and treat this highly preventable form of cancer. In the process, epidemiological studies have contributed evidence suggesting that certain risk factors associated with cervical cancer – tobacco use,

\(^{24}\) The arguments related to cervical cancer are discussed in Browne and Smye (2002).

\(^{25}\) Cervical cancer mortality during 1991-2000 was twice as high for status First Nations in BC than for other BC women (BC Provincial Health Officer, 2002). Recent data from other provinces also show that risk factors for cervical cancer remain 1.8 to 3.6 times higher for Aboriginal women (T.K. Young, Kliewer, Blanchard & Mayer, 2000).
sexual activity before age 18, multiple partners, and infection with the human papilloma virus – may be higher among Aboriginal women than non-Aboriginal women (T.K. Young, McNicol & Beauvais, 1997). While it is important to formulate risk-profiles for prevention purposes, when discussed out of context, these risk factors can be attributed by health professionals (and the public at large) to women’s lifestyle or personal choices. Herein lies the potential danger. Removed from their historical, social and economic contexts, discourses about reproductive risk factors or at-risk groups have the potential to be reified into a lifestyle or behavioural syndrome (Fraser & Gordon, 1994) encompassing negative stereotypes about Aboriginal women as lascivious, or as lacking will power, judgment or moral fortitude. Recognizing this danger, and to mitigate these negative stereotypes, Aboriginal women in BC involved in a Pap testing demonstration project requested that information about risk factors not be widely publicized for fear of further stigmatizing women in the eyes of the public (Clarke, 1997). Despite these efforts, concerns remain among Aboriginal leaders and researchers about the propensity of dominant epidemiological discourses to perpetuate damaging images of Aboriginal peoples and communities (O’Neil et al., 1998).

Relations of surveillance are beginning to shift as communities and Nations have gained administrative control of federal health and social programs through Health Transfer agreements (O’Neil et al., 1999). Communities are undertaking independent research on health issues to advance community-defined goals; ownership of health information and its presentation in the public eye is clearly recognized as a component of self-government (O’Neil et al., 1998). Nonetheless, enduring images of Aboriginal communities as destitute,

The media, for example, frequently profile health and social conditions in Aboriginal communities. Presented (and read) as official, authoritative discourses, news stories shape the public’s selective understandings of Aboriginal peoples and Aboriginal-state relations (Furniss, 1999). Recently, national news stories have covered the high rates of gas sniffing among youth in Davis Inlet (Band Council, 2002). Newspapers have described how “drunk adults and kids high from sniffing gas often get in trouble, hurting themselves or others” in Shamattawa (Suicide Stalks, 2002). To mark the five years since the release of the *Royal Commission on Aboriginal Peoples*, Canada’s *Globe and Mail* published a series of articles in response to two central questions: “Are Aboriginal people really second-class citizens? If so, will they always be?” (Stackhouse, 2001a). Despite journalists’ attempts to present a balanced perspective, several articles presented messages about Aboriginal peoples that easily reinforce negative stereotypes. For example, articles depicting “Indian women bloodied and bruised, with little children abandoned in the dead of night,” and “native organizations that want to handcuff the cops” continue to shape Canadians’ popular consciousness (Stackhouse, 2001b). The power of these official, popularized discourses lies in their propensity to be taken up as taken-for-granted truths about Aboriginal peoples and Aboriginal-state relations. As discussed below, when social tensions rise over competition for diminishing economic resources and cutbacks, messages and mis/information about Aboriginal peoples become even more visible as issues related to land claims, rights and entitlements are debated in public venues (Furniss, 1999).
Situating Current Aboriginal-State Relations

From the perspective of many Aboriginal peoples, self-government\textsuperscript{26} is vital to breaking the cycle of poverty, economic marginalization and persistent disadvantage (O’Neil et al., 1999). Recognizing the fundamental importance of self-government, a large proportion of First Nations communities and political organizations are in the midst of intense treaty and land claim negotiations (Hylton, 1999)\textsuperscript{27}. In BC, political tensions have grown in relation to these negotiations\textsuperscript{28}. Tensions culminated as the BC Liberal government geared up for a treaty referendum in May 2002, ostensibly launched to permit public input into treaty negotiations. In the months leading up to the referendum – coinciding with the data collection phase of the dissertation – a flurry of highly publicized debates and public forums occurred around issues of Aboriginal rights and entitlements. From the viewpoint of First Nations in BC, the referendum provided a means for the newly elected Liberal government “to validate and accelerate the open access to Crown lands for big businesses – land that is often the centre of ongoing Aboriginal title disputes” (BC Bands, 2002, p. 3). Members of the Legislative Assembly, voicing their opinions in local newspapers, cast the referendum as

\textsuperscript{26} Michael Asch (2002) defines self-government as “the ability of a group to govern its lands and the people on them by setting goals and acting on them without having to seek permission from others” (p. 66).

\textsuperscript{27} As examples, between 1970 and 2002, there were a total of 1,154 national claims (428 of these within BC) either under review, under negotiation, settled, in litigation or closed (Indian and Northern Affairs Canada, 2003a, 2003b). In 1997, approximately 80 self-government agreements were under negotiation among First Nations and Inuit communities/political bodies, and federal, provincial and territorial governments (O’Neil, 1999).

\textsuperscript{28} BC is the only province in which treaties between First Nations, provincial and federal governments have not been signed (Asch, 2002). In 1995, the Nisga’a, who had negotiated with the federal government since 1976, signed an agreement in principle with the federal and provincial governments, which marked the closest step toward a modern treaty in BC (Furniss, 1999). From the perspective of First Nations, since no lands in BC were ceded or sold, Aboriginal title persists to the present day (Culhane Speck, 1987). Furthermore, as Thomas Berger (2002) explains, the Constitution and Charter of Rights adopted in 1982 established that Aboriginal self-government is a constitutionally protected Aboriginal right, and when recognized in a treaty, a constitutionally protected treaty right.
a call to "the good judgment of the average British Columbian and their recognition of the fact that this [treaty issue] is unfinished business" (Hoekstra, 2001, p. 3). Public reactions were diverse: some non-Aboriginal organizations expressed their full support of First Nations’ positions29 (LeMoal, 2002a, 2002b). The dominant majority, however, are generally more uniform and vocal in their public opposition to recent land claim settlements and ongoing treaty negotiations (Furniss, 1999).

Perhaps more than any other issue, the land question illustrates how Canada’s colonial legacy intersects with current economic, social and political factors to shape and maintain the existing material privilege of the dominant sector. The lands and resources under question – traditional Aboriginal territories – overlap with fishery, forestry, mining, agricultural and park areas (Furniss, 1999). Negotiations for the transfer of ‘Crown’ lands to Aboriginal organizations necessarily involve economic conflicts. In resource dependent BC communities, the ongoing conviction is “that Aboriginal treaties pose a serious threat to the survival of resource-dependent jobs, industries, and communities” (Furniss, 1999, p. 140). While economic interests are the fulcrum around which treaty/land issues are discussed, public oppositional discourses and everyday conversations draw on various strands of colonial discourses and common-sense assumptions about “undeserving Indians” (p. 152) who “are not ready” (p. 151) for treaties and for whom self-government would be “a disaster” (p. 151).

29 Of the 2.2 million referendum ballots sent to BC voters, approximately 725,000 or 35% of the province’s registered voters, were mailed back to the provincial government. This was reported to be “the lowest participation level ever for a provincial vote” (LeMoal, 2002b, p. 1). Opposition to the BC referendum process came from diverse organizations ranging from human rights, churches, labour and environmental groups (BC Bands, 2002; LeMoal, 2002a, 2002b).
Arguably the most powerful of oppositional arguments draws on moral discourses of Aboriginal inferiority. Furniss (1999) explains:

The idea of the inherent moral inferiority of Aboriginal people – whether due to race, culture, or historical circumstance – underlies the widespread conviction that Aboriginal people simply do not ‘deserve’ treaty settlements (p. 162).

Similar to colonial justifications used in the past, current social conditions – poverty, high rates of substance abuse, unemployment and poor living conditions – are drawn on as evidence of Aboriginal peoples’ inability to govern their affairs. In BC, public opposition to Aboriginal land claims (and all that they represent in terms of Aboriginal rights and entitlements) are expressed regularly, though couched in varying forms. An extreme example occurred during the lead-up to the referendum when a provincial “White Pride” website was established in support of the referendum (LeMoal, 2002a, p. 1). This incident, among others, confirmed the suspicions of many First Nations leaders: as Stewart Philips, President and Chief of the Union of BC Indian Chiefs, argued, “This underscores and confirms our greatest concerns with respect to the referendum being exploited by racist groups to advance their agenda” (LeMoal, 2002a, p. 1). Subsequently, he went on to say, “We have stated from the beginning that this [the referendum] is a deliberate effort to manipulate public opinion against the aspirations of first nations [sic] at the negotiation table” (LeMoal, 2002b, p. 3).

The threat to liberalist perceptions of equality and equal treatment under Canadian law is a primary reason for lack of public support for Aboriginal rights (Asch, 2002). In northern BC, members of the Reform party have carried the notion of “one law for all Canadians” to an extreme, mobilizing liberal principles of equality to denounce Aboriginal treaties as furthering racism (Furniss, 1999, p. 150). Appealing to widely recognized liberal
principles\textsuperscript{30}, arguments about the importance of equality and fairness are promoted while policies and political practices supporting structural inequities for Aboriginal peoples are perpetuated.

To summarize, the political climate shaped by the referendum, pending settlements, and most recently, tactics used by the BC Liberals to slow treaty and land claim negotiations in several jurisdictions provide a context for examining everyday Aboriginal/non-Aboriginal relations. Discourses generated about the wide range of related issues find expression in the popular media, shape public consciousness, and are reinforced in everyday conversations. As illustrated in subsequent chapters, the messages and images about Aboriginal peoples produced through dominant discourses shape relations between Aboriginal and non-Aboriginal peoples – including nurses and patients.

**Health Care Restructuring: The Context of Nurses’ Work**

The current context of health care restructuring and reform also informs the analysis of health care interactions undertaken in this dissertation. In an effort to curtail rising costs and enhance efficiencies, restructuring nationally and in BC has involved major reorganization, streamlining and amalgamation of institutions, agencies and resources. In December 2001, the BC Liberal government introduced its health care restructuring plan, *A New Era in Patient Centred Care*, which collapsed what had been 52 different health authorities into five health authorities (BC, 2001). The overall goal has been to “improve efficiency, strengthen accountability and allow better planning and service coordination….and to create a sustainable, affordable public health system” (p. 1).

\textsuperscript{30} The central tenets of liberal political ideology have been discussed in Browne (2001).
This massive reorganization has been critiqued on a number of fronts. Varcoe and Rodney (2002) have argued that the motivation behind reform reflects a distinctly corporate ideology that ultimately privileges cost containment over accessibility and quality. In the context of reform, cost containment measures have resulted in hospital downsizing, shortened lengths of hospitalization, casualization of the nursing workforce, a reduction in front-line management positions, and the replacement of nursing staff positions with licensed practical nurses and nurses' aides (Canadian Nurses Association, 2001). Research has documented the harsh impact on frontline nurses as workloads, patient acuity, and nursing shortages have escalated while support and resources for nurses have diminished (Bauman et al., 2001; Canadian Nurses Association, 2001; Laschinger, Sabiston, Finegan & Shamian, 2001). Most significantly, these studies have shown how the quality of care that nurses are able to provide under these conditions is compromised.

The tension between organizational restructuring and the provision of acceptable, high quality care is felt in the everyday realities of health care provision (Anderson, Tang & Blue, 1999). Nurses’ everyday work is increasingly organized around efficiencies focused on the most urgent (typically physical) aspects of patient care at the expense of attending to patients’ emotional or psychosocial needs (Lynam, et al., in press; Varcoe & Rodney, 2002). While patients may perceive that they are receiving competent health care, health care providers are voicing major concerns about their ability to meet basic standards of care (Anderson et al., 1999; Armstrong & Armstrong, 2003; Lynam). As Lynam et al. explain, the current practice climate places nurses and other health care providers in the position of having to ration the care they provide, choosing between approaches to care on the basis of urgency and expediency rather than efficacy.
One of the most pressing issues affecting the provision of services in hospitals has been an escalating nation-wide shortage of registered nurses (Canadian Nurses Association, 2001). In northern regions of BC, as in other rural and northern jurisdictions, there remain tremendous difficulties recruiting and retaining both physicians and nurses. This has exacerbated pre-existing strains on the system. Coverage of the ongoing shortages have been featured frequently in the popular media. Closures of small rural hospitals and the withdrawal of specialist services in northern regions have fueled perceptions of a health care crisis. As I discuss in subsequent chapters, the persistent portrayal of a health care system in crisis influences the expectations of patients and families about the quality of care they hope to receive.

Current tensions in the acute care sectors rose sharply in the months just before data collection for the dissertation began. Concerned about the ability of nurses to meet their practice standards in the face of nursing shortages and restructuring, the BC nurses’ union launched an overtime ban in an effort to stimulate action. The overtime ban ended just as the study began (due to government legislation, not resolution of issues); however, throughout the study, nurses expressed tremendous concerns about the nursing shortage, their unreasonable workloads, and ultimately, the challenges they faced in meeting basic standards of care. These workplace realities formed the context in which nurse-patient interactions transpired.

**Approaches to the Study of Health Care Interactions**

Inquiry into the dynamics of interactions between health professionals and patients has been a leading topic in social and health research for the past several decades (Anderson et al., 1997; Fisher, 1991, 1995; Furst, 1998; Kleinman, Eisenberg & Good, 1978; Lazarus,
1988; O'Neil, 1989; Singer & Baer, 1997; Todd, 1989; Todd & Fisher, 1993). The infusion of social science perspectives into health science disciplines has illuminated the complexity of health care encounters in shaping health care (Anderson et al., 1997). Typically, studies of health care interactions have focused on doctor-patient relationships (e.g., Hahn, 1995; Kleinman et al., 1978; Todd; Todd & Fisher; Waitzkin, 1991). Many of these scholars have taken a critical analytical approach by focusing on the social, economic, political and historical determinants of health care as they affect the root causes of health and illness; power differentials and social conflict in health care; the capacity of people to undertake health-related activities and negotiate health sectors from which they have been marginalized; and professional control of health services (Ahmad, 1993b; Singer & Baer, 1997; O'Neil, 1989). From this critical perspective, the factors that influence health care interactions are understood as occurring within a set of wider social relations that, though typically not visible, profoundly influence patient-provider relations.

Despite commitments to ideals of egalitarianism and equity in health care, research has shown that health professionals respond differently to patients who are differently situated with respect to gender, economic class, educational level, 'race', and ethnicity, among others (Krieger, 2000; Sherwin, 1992; Todd & Fisher, 1993). In a society characterized by asymmetrical relationships – white/non-white, wealthy/poor, marginalized/mainstream, working/unemployed, professional/non-professional – health care relations often reproduce and reinforce this lack of symmetry, making some patients especially vulnerable (Sherwin).

Anderson’s and Reimer Kirkham’s research (Anderson et al., 1997; Anderson, 1998b; Anderson & Reimer Kirkham, 1998; Reimer Kirkham, 2000) suggests that the power
relations studied within the doctor-patient relationship also influence nurse-patient relations. These power differentials are magnified when gender, racial background, culture, and class are considered. Despite the extent of contact between nurses and patients (particularly in northern or rural settings where nurses are often the first point of contact), few published studies have examined issues of racism, gender or class relations as they pertain to nurse-patient interactions (Culley, 1996; Meleis & Im, 1999; Reimer Kirkham, 2000). Even fewer studies have examined these issues in relation to interactions involving Canadian Aboriginal patients (exceptions include, for example, Baker & Daigle, 2000; Browne, 1995, 1997; Browne & Fiske, 2001; O’Neil, 1989).

To date, there are only a limited number of studies examining patient-provider interactions involving Aboriginal patients and non-Aboriginal providers in the Canadian context. This gap in the literature exists despite a growing body of research showing how the dynamics of patient-provider interactions strongly influence patients' experiences obtaining health care, satisfaction with care, and ultimately access to and use of health care (e.g., see Lazarus, 1988; Singer & Baer, 1997; Todd & Fisher, 1993).

Of those studies that have examined health care encounters involving Aboriginal patients, most have maintained a gender-neutral perspective. In this study, gender is not conceptualized in terms of biological differences; rather I examine the ways in which gender interacts with 'race' and class relations to organize people's experience (Anderson, 1998b). The under-representation of Aboriginal women in health care and on decision-making bodies (such as health boards), for example, illustrates how First Nations women continue to be marginalized in relation to the mainstream health care system\(^\text{31}\). This visible and obvious

\(^{31}\) A reliable estimate of the number of registered nurses in Canada who self-identify as Aboriginal is difficult to obtain since nurses have the option to self-identify or not when they are registered or employed (Office of
marginalization contributes to women's sense of being on the outside of the system even as essential services are sought (Browne & Fiske, 2001; Dion Stout & Kipling, 1998).

O'Neil's (1989) hallmark study of health care encounters involving Inuit patients and Western health care providers has been highly influential in drawing attention to the political context of patient dissatisfaction. By situating individual patient-provider interactions within the internal colonial context of health care in northern Canada, O'Neil demonstrated how paternalism, power differences, and cultural misunderstandings were shaped by wider sociopolitical issues. O'Neil argued further that the tendency of Western nurses and doctors to bracket out the sociopolitical context of health care encounters involving Aboriginal patients stemmed from their professional socialization and predominantly middle-class values. In these situations, the potential was high for seemingly innocuous behaviours to be interpreted by patients as racist.

The few studies that followed O'Neil's work have continued to emphasize the need to locate the micropolitics of health care within broader sociopolitical and historic contexts. Sherley-Spiers' (1989) study involving Dakota patients, and Browne's (1995) study involving Cree-Ojibway patients found that patients readily interpreted covert (and overt) messages and attitudes conveyed by their providers in relation to broader issues of discrimination, stereotyping and victim-blaming. Mi'kmaq patients in Baker and Daigle's (2000) study felt they had entered an unfamiliar world while in the hospital, perceiving themselves as misunderstood and "lessened as a person" (p. 17) by negative experiences, and understood and "treated as equal" (p. 20) during positive experiences. Their findings suggested that "compassion and a nondiscriminatory attitude were more important than

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Nursing Services, Health Canada, personal communication, November 13, 2002). In 1997/1998, it was estimated that there were 800 Aboriginal nurses (Romanow, 2002).
According to patients, culture played an insignificant part in descriptions of “good care” (p. 22). Instead, patients focused on nurses’ ability to convey a non-discriminatory and accepting attitude toward them.

Recent research undertaken by Browne and colleagues (Browne et al., 2000; Browne & Fiske, 2001) focused specifically on patient-provider interactions involving First Nations women. Overall, findings illustrated how intersecting issues of gender, ‘race’ and class shaped women’s experiences as they sought health care for themselves or their families. For example, the women questioned whether their health care provider’s dismissal of their health concerns stemmed from his or her stereotypes of First Nations women as bad mothers, neglectful or irresponsible. In an effort to transform dismissive interactions into attentive interactions, participants changed their appearance and manner of speaking to overcome perceived cultural differences. These acts of transformation were understood as a means of obtaining credibility and legitimacy as medical subjects. When the women discussed positive health care encounters, these represented unexpected exceptions to ubiquitous forms of everyday discrimination that shaped their lives. Together, the studies reviewed above highlight the need for analyses that link the dynamics of patient-provider relationships to wider structural and systemic issues.

**Summary: The Past Informs the Present**

Examining the significance of past colonial relations is necessary to understanding current social, political and economic conditions influencing Aboriginal health, Aboriginal-state relations and public perceptions of Aboriginal peoples. In particular, I have emphasized how colonizing images continue to influence the collective consciousness of non-Aboriginal Canadians and shape conventional attitudes toward Aboriginal peoples. As I argue later,
perceptions, images and messages about Aboriginal peoples originating outside “the clinic” infiltrate relations within the hospital.

Few studies have examined patient-provider interactions involving Aboriginal patients and non-Aboriginal health providers. Even fewer have critically examined relationships between nurses and patients as mediators of equitable health care. This gap limits our understanding of a significant dimension of nurses’ work in areas where there are high proportions of Aboriginal patients. The study presented here aims to address this gap by examining how history and current sociopolitical conditions shape health care encounters between nurses and First Nations women. As discussed in the next chapter, I proceed with this analysis by viewing nurse-patient relations through a particular theoretical lens informed by postcolonial and feminist perspectives.
CHAPTER THREE

THEORETICAL FRAMEWORK

Introduction: Postcolonial Theoretical Context

Over the past several decades, critical perspectives derived from feminism, critical social theories, postmodernism, poststructuralism and cultural studies (among others) have been influential in focusing attention in nursing scholarship on the complex layers of contexts in which people experience and interpret health, illness and health care (Reimer Kirkham & Anderson, 2002). Most recently, the field of critical inquiry in nursing has been influenced by a call for the infusion of postcolonial theoretical perspectives. Although postcolonial discourses are still infrequent in nursing, their integration into nursing science provides an alternative to culturalist approaches that continue to predominate in nursing theory. Reimer Kirkham and Anderson explain the tenets of postcolonial nursing scholarship:

Postcolonial theory with its interpretations of race, racialization, and culture offers nursing scholarship a set of powerful analytical tools unlike those offered by other social theories (p. 9).... [P]ostcolonial research inevitably explores at some level the two meta themes of race (with its adjuncts of colonization, ethnicity, hybridity, intersecting oppressions, and so forth) and power (in its various expressions)....A postcolonial nursing scholarship pursues, then, these matters of how contemporary constructions of race, ethnicity, and culture continue to rely on colonialist images and patterns of inclusion and exclusion within health care settings. (p. 10)

In the previous chapter, I outlined the significance of locating an analysis of Aboriginal women’s health within the historical context of colonialism and today’s internal colonial context. Postcolonial theoretical perspectives have obvious relevance to the objectives
pursued in this dissertation. The research I present, therefore, is positioned within the emerging body of postcolonial nursing scholarship.

Postcolonial scholarship, however, does not necessarily include a gendered analysis or perspectives from feminist scholarship (Gandhi, 1998). To address this gap, postcolonial scholars have drawn on feminist theories to write in analyses of colonial relationships as they are organized by gender, race and class, “not as distinct realms of experience”, but as “they come into existence in and through relations to each other” (McClintock, 1995, p. 5). Given my own positionality within the field of Aboriginal health, I am also conscious of the need to engage critically with postcolonial and feminist theories. The chapter, therefore, opens by scrutinizing what some might consider an imposition of Eurocentric theoretical perspectives onto issues of central importance to Aboriginal peoples. To do so, I draw on the works of Aboriginal scholars who have considered the applicability of postcolonialism to Aboriginal issues. I then examine in more depth the theoretical foundations of postcolonialism. This is followed by a discussion of the dimensions of feminist theory that I incorporate into a postcolonial framework, particularly as they relate to notions of intersectionality and the positioning of marginalized voices. I also present an analysis of the various viewpoints of Aboriginal scholars who have considered the value and problems inherent in applying feminist theories. Having considered these theoretical strengths and limitations, I return to consider how key concepts of racialization, difference, culture and culturalism are understood within postcolonialism. The chapter ends with a discussion of cultural safety as a relatively new postcolonial concept focused on historical patterns of power and paternalism in nurse-patient interactions.
Aboriginal Scholars’ Engagement with Postcolonial Discourses

Clearly, it is not reasonable to expect a unified position among Aboriginal scholars on theoretical perspectives as wide-ranging as postcolonial and feminist perspectives. Nonetheless, it is reasonable to claim that Aboriginal scholars who address issues of importance to Aboriginal peoples share concern over “the burden and contradictions of colonial history” (LaRocque, 1996, p. 14). For LaRocque, the value of situating critical inquiries addressing “Native/white” relations in a postcolonial context lies in explicating “colonization as a pervasive structural and psychological relationship between the colonizer and the colonized” that is “ultimately reflected in the dominant institutions, policies, histories, and literatures of occupying powers” (p. 11). LaRocque writes:

In other words, we must seek to understand what happens to a country that has existed under the forces of colonial history over such an extended period of time. We must seek to recognize the faces of both the colonizer and the colonized, as they appear in society and in the academic community. We must become aware of the functions of power and racism, its effects of the Native populations, and the significance of resistance. (p. 11)

Recently, a growing number of Aboriginal scholars have contributed to postcolonial discourses as a way of reclaiming and repositioning indigenous voices, knowledge and analyses (Battiste, 2000). Cautious of adopting Eurocentric theories to examine issues of concern to Aboriginal peoples, Marie Battiste (2000), a Mi’kmaq scholar and professor, emphasizes:

Postcolonial Indigenous thought should not be confused with postcolonial theory in literature. Although they are related endeavours, postcolonial Indigenous thought also
emerges from the inability of Eurocentric theory to deal with the complexities of colonialism and its assumptions. (p. xix)

From Battiste’s perspective, the value of postcolonial indigenous thought is in visioning and shaping a more just postcolonial society using complex “transformative strategies” that “engage with and react to the multiple circumstances and shapes of oppression, exploitation, assimilation, colonization, racism, genderism, ageism, and the many other strategies of marginalization” (p. xxi). Battiste’s framing of postcolonial indigenous thought has resulted in a collection of works by indigenous scholars from Canada, the USA and New Zealand who provide new frameworks for understanding the complexities of colonization and decolonization.

For LaRocque (1996), the growing body of literature on “post-colonial voices” (p. 13) indicates the extent to which Canadian Aboriginal peoples – as members of international indigenous communities – are responding and “emerging ‘in our present form out of the experience of colonization’ and asserting ourselves ‘by foregrounding the tension’ within the colonial power by writing or talking back to ‘the empire’” (Ashcroft, Griffiths & Tiffin, 1989, cited in LaRocque, p. 13). Of vital importance is the emphasis placed by Aboriginal scholars on postcolonial discourses as tools for challenging their non-Aboriginal colleagues to “re-evaluate their colonial frameworks of interpretation, their conclusions and portrayals, not to mention their tendencies of excluding from their footnotes scholars who are Native” (LaRocque, p. 13). Recognizing the contestations inherent in the broad range of theories contributing to postcolonialism, these are the applications of postcolonialism that I turn to for their potential to challenge and disrupt the reproduction of colonial social formations (McConaghy, 2000).
Theoretical Foundations of Postcolonialism

Postcolonial critique, as described by R.J.C. Young (2001) is united by a common political and moral concern about the history and legacy of colonialism. In its broadest sense, postcolonialism can be defined as an inherently interdisciplinary project devoted to the tasks of “revisiting, remembering and crucially, interrogating” the colonial past and aftermath (Gandhi, 1998, p. 4). As a discourse, postcolonialism is framed as a historical condition rather than as a chronological period (Anderson, 2002; Ashcroft, Griffiths & Tiffin, 1998). The notion of ‘post’ in postcolonial does not imply that we have moved past or beyond hegemonic power-knowledge regimes, but that “‘emergent’ new configurations of power-knowledge relations are beginning to exert their distinctive and specific effects” (Hall, 1996d, p. 254). Rather than signifying a temporal location, Cathryn McConaghy (2000), an Australian scholar, explains the postcolonial “as a place of multiple identities, interconnected histories, and shifting and diverse material conditions. It is also a place where new racisms and oppressions are being formed” (p. 1).

Scholars such as Homi Bhabha (1994) have stressed that “it is from those who have suffered the sentence of history – subjugation, domination, diaspora, displacement – that we learn our most enduring lessons for living and thinking” (p. 172). Drawing on Homi Bhabha (1994) to address indigenous peoples’ concerns, McConaghy describes the postcolonial as a time for reflecting, a moving back and forth and beyond the colonial. She explains this

32 Gramsci (1971), the Italian Marxist jailed by fascists in the 1920s, was influential in forming our current understanding of hegemony as the ways in which specific institutions operate in the social reproduction of power relations through ideology. Hegemony can be defined as the power exercised by some social groups over others and as the ideological/cultural domination of particular groups achieved by engineering consensus through controlling the content of cultural forms and major institutions (Jary & Jary, 1991). Building on Gramsci’s works, Stuart Hall (1986/1996a) explains that hegemony is not simply imposed or domineering in character. Rather, it results from (a) “the installation of a profound measure of social and moral authority,” (b) the “winning over” of the popular consent of substantial proportions of the population including subaltern and dominated groups, and (c) exercise of this authority in a diversity of sites (e.g., health care arenas, economic sectors, and popular media) (p. 424).
reflexive process characterizing the postcolonial as “a sign that we are now more aware of our historical locatedness, less sure of the rightness of our policy decisions, more alert to the possibility that our decisions may be colonizing rather than decolonizing in their consequences, more able to be responsive to new situations of disadvantage and more able to correctly analyze and redress the specifics of local oppressions” (1997, p.86).

Postcolonial theorizing, initially articulated in the anti-colonial writings of Frantz Fanon, Aimé Césaire, Albert Memmi and others, provided provocative analyses of particular sites and dimensions of colonial domination and oppression (McConaghy, 2000). Edward Said’s (1978) highly influential text, *Orientalism*, was instrumental in revealing the extent to which colonial ideology permeated virtually all facets of Western knowledge, science, literature and culture to provide “a political vision of reality whose structure promoted a binary opposition between the familiar (Europe, the West, ‘us’) and the strange (the Orient, the East, ‘them’)” (Said, 1978, cited in Loomba, 1998, p. 47). Influential writers following Said (e.g., Stuart Hall, Homi Bhabha, Gayatri Chakravorty Spivak, and Chandra Mohanty, among others), incorporated theoretical perspectives from literary theory, cultural studies, sociology, postmodernism, poststructuralism, and more recently, neo-Marxism and feminism (Reimer Kirkham & Anderson, 2002). These divergent disciplinary applications preclude any single, unified conceptualization of postcolonialism. The proliferation of increasingly diffuse uses of the term postcolonial in the past 15 years has risked diverting attention away from the historical process of colonization (Ashcroft, Griffiths & Tiffin, 1995). Nonetheless, there remain several themes that are characteristically associated with postcolonialism. These include race, difference, culture, ethnicity, nation, power, subalterns, subjectivity, identity and hybridity, and their various manifestations within shifting postcolonial climates (Ghandi,
In this dissertation, the focus is on race, racialization, culture and difference as the key analytical concepts: these are discussed in more depth later in the chapter.

Postcolonial discourses have also come under scrutiny for reproducing the very practices they aim to disrupt. They have been criticized for reverting to the politics of binary oppositions (i.e., colonized and colonizer) (Hall, 1996d), thereby ignoring the complexities and shifting ambiguities of political positionalities (McConaghy, 2000). Concern has also centred on the presumption of an essentialized, shared experience of colonization among members of a group (Reimer Kirkham & Anderson, 2002). The preoccupation with questions of race, ethnicity and culture to the exclusion of other forms of colonial oppression based on gender, class and nation also carry the risk of privileging one set of oppressive relations over another. With these caveats in mind, I argue that there is value in integrating postcolonial perspectives into nursing inquiries that address issues of concern to Aboriginal health and health care, particularly because of the explicit and continuing after-effects of colonialism on the health and social status of Aboriginal peoples in Canada.

Perspectives from Feminist Theories

The strands of feminist theory that I position within a postcolonial framework provide a foundation on which to implement praxis-oriented inquiry. In particular, selected

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33 As McCormick and Roussy (1997) explain, "The notion of praxis acknowledges that research and practice are inevitably theory-laden and that these theories are influenced by individuals' ideological commitments....Nurses who have a commitment to critical nursing praxis recognize the importance of theoretical perspectives that help expose the power and hierarchy embedded in the social world in which health care decisions are made" (p. 269, 279). Praxis-oriented inquiry in an emancipatory context, therefore, refers to research and knowledge development focused on "generating useful or practical knowledge, interrupting patterns of power, participating in socially transformative processes toward such ideals as justice, equity, and freedom" (Thorne, 1997, p. 126).
discourses within feminist theory shape my theoretical suppositions about intersectionality, positionality, voice, and socially constructed knowledge.

**Intersectionality**

Increasingly, scholars are using the concept of intersectionality advanced by feminist theorists such as Collins (1991, 1998, 2000) and Brewer (1993) to describe the multiple constraints and layers of contexts that organize peoples’ experiences (Anderson, et al., 1997). Collins (1998) writes:

> As a heuristic device, intersectionality references the ability of social phenomena such as race, class, and gender to mutually construct one another. One can use the framework of intersectionality to think through social institutions, organizational structures, patterns of social interactions, and other social practices on all levels of social organization. Groups are constructed within these social practices, with each group encountering a distinctive constellation of experiences based on its placement in hierarchical power relations (p. 203).

In the case of many Aboriginal women, poverty, the legacy of historical subjugation, and racism are such “tightly bundled” constructs that an understanding of one is lost without reference to the other (Collins, 1998, p. 209). For example, when gender interacts with other factors such as lower levels of education, ‘race’, or single parenthood, women end up at the

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34 My use of the concept of intersectionality, most often associated with Black feminist thought, does not imply that the entire project of Black feminist thought is applicable to the study of Aboriginal women’s health. Rather, I draw on selected aspects within this theoretical orientation to guide my analysis.

35 Collins and Brewer identify as Black feminist theorists. The term Black, within the body of theory known as Black feminist thought, reflects the positionality of Black women living in countries of the North; it does not, however, necessarily imply an Afro-centric approach (Anderson, 2002). Rather, Black is sometimes used interchangeably with “women of Colour” as in Carty’s (1991) and Anderson’s (2000a, 2002) work to acknowledge a common (though differently experienced) context of struggle shaped by common elements of systematic discrimination.
bottom of most socioeconomic gradients, with Aboriginal women representing one of the most disadvantaged\footnote{Monture Angus (1995) has problematized the term “disadvantaged” as it is often used in relation to Aboriginal peoples. She argues that disadvantage erases the many strengths within Aboriginal communities—the sense of family, community and cultural pride, and belongingness, for example. In light of Monture Angus’ caveats, I wish to clarify that disadvantage is used in this study to refer to the material constraints under which many Aboriginal women and their families live, and the ongoing marginalization of many from educational, economic and political opportunities that might otherwise help to improve their material circumstances.} groups in Canada (Dion Stout & Kipling, 1998). Recognizing the shifting nature of these intersecting constraints helps to explain how all groups “possess varying amounts of penalty and privilege in one historically created system” (Collins, 1991, p. 225). In this study, the notion of intersectionality is used to examine the multiple, intersecting factors influencing women’s experience of health care.

**Positioning Marginalized Voices and Knowledge**

A central feature of postcolonial feminist nursing scholarship is “the deliberate decentering of dominant culture,” and “the weaving of the perspectives and experiences of those marginalized in our society into the very fabric of our nursing science” (Reimer Kirkham & Anderson, 2002, p. 12). In forming my understanding of ‘voice,’ I draw on LaRocque’s (1996) notion of voice as “a textual resistance technique” (p. 13). LaRocque notes:

> It should not be assumed, as it so often is, that using ‘voice’ means ‘making a personal statement,’ which is then dichotomized from ‘academic studies’. Instead, ‘voice’ can be, and must be, used within academic studies not only as an expression of cultural integrity but also as an attempt to begin to balance the legacy of dehumanization and bias entrenched in Canadian studies about Native peoples. (p. 13)
LaRocque’s view resonates with a central epistemological assumption advanced by feminist theorists such as Smith (1987, 1992) and Collins (1991, 2002) who concur that “some social locations are better than others as starting points for knowledge projects that seek to understand oppressive social relations” (Mann & Kelley, 1997, p. 397). This is not to undermine knowledge developed from other locations. Rather, my interest is in beginning inquiry from the standpoint of nurses and First Nations women as a way of making transparent the processes of colonization, neocolonialism, racism, racialization and other forms of oppression (Anderson, 2000a).

From these particular feminist perspectives, forms of knowledge considered legitimate include experiential, subjectively derived knowledge and intersubjective knowledge (Harding, 1987). Subjectively based knowledge assumes that knowledge about our world and society can be gained “from inside, hence subjectively” (Smith, 1987, p. 122). Accepting the validity of subjective knowledge, however, does not imply a relativist approach to knowledge development. Rather, feminist theorists like Smith (1987, 1992) and Collins (1991) argue against relativist views of subjectivity as existing only within the subjective make-up of individuals (Mann & Kelley, 1997). Instead, Smith (1990) stresses that people’s subjective interpretations of their experiences must be grounded in their everyday material conditions. Socially constructed knowledge from these perspectives does not, therefore, derive from a relativist or idealist ontological position as some constructivist paradigms propose. To the contrary, for both Smith and Collins, socially constructed knowledge derives from (and is grounded in) realist assumptions about the material and social conditions which shape experiences, understandings and knowledge development (Mann & Kelley).
In a research context, from a feminist perspective, knowledge that is socially constructed derives from a dialectical, reflexive process occurring between researchers and participants (Anderson, 1991a). The link between reflexivity and social constructions of knowledge is, therefore, a central epistemological assumption in feminist inquiry. As such, reflexivity will be discussed in greater depth in Chapter Four, both as a methodological issue and as a criterion for assessing scientific rigour. At this point, my concern is with the theory I am applying. In particular, feminist perspectives have been viewed with caution and scepticism by some Aboriginal women and scholars. In the analysis that follows, I therefore grapple with some of the implications of drawing on feminist perspectives to examine issues pertaining to Aboriginal women.

Aboriginal Perspectives on the Relevance of Feminist Theories

In remaining accountable to the views of Aboriginal scholars and theorists as I develop my own work, I ask the questions that Jo-Anne Fiske (2000a), a non-Aboriginal anthropologist, asks of her own work: “Have scholarly agendas paid attention to Aboriginal women’s self-definitions and agendas? How have these agendas been expressed in scholarly studies? How have we who are non-Aboriginal scholars responded to Aboriginal women’s critiques of feminist discourses and political agendas? How have Aboriginal women adopted or resisted feminism?” (p. 12).

From the vantage point of several leading Aboriginal scholars, feminism represents contested territory for several reasons. One of the most significant relates to feminism itself as “located within discourses and practices of hegemonic nationalism” (Lee & Cardinal, 1998, p. 217). As Lee and Cardinal explain, although feminism has achieved gains for many Anglo, middle-class women, “these gains have come about by ignoring differences among

37 The type of feminism referred to is primarily that of liberal, mainstream feminism (Ginn, 1998).
women and excluding women who stand outside the imagined national community” (p. 217). Thus essentialist claims about women in liberal feminist theory have been critiqued for their hegemonic focus on the problems and issues of privileged – most often White, Western, middle-class and heterosexual – women (Narayan, 2000).

Patricia Monture Angus (1995), a Mohawk law professor, addresses the relevance of mainstream feminism to the concerns of Aboriginal women. Monture Angus takes issue with the fact that the “women’s movement has never taken as its central and long-term goal, the eradication of the legal oppression that is specific to Aboriginal women” (p. 175). She and other Aboriginal scholars such as Stevenson (Johnson, Stevenson & Greschner, 1993) and Turpel (1993) point out that until recently, colonialism (or internal colonialism) has rarely been incorporated in feminist analyses of oppression, thus diminishing the impact of racial and cultural oppression in neo/post/colonial contexts. As Monture Angus argues,

The patriarchal nature of the state has different meanings and consequences from the vantage point of Aboriginal Peoples. Understanding how patriarchy operates in Canada without understanding colonization is a meaningless endeavour from the perspective of Aboriginal people. (p. 175)

Although Monture Angus does not view her position as anti-feminist per se, ultimately she sees “feminism as removed from the colonial practices of this country” (p. 177). Turpel (1993) echoes Monture Angus’ views arguing that the historical differentiation of forms of oppression applied to Aboriginal and non-Aboriginal women “is one of the most important points for feminists to grasp in order to appreciate how state-imposed gender discrimination uniquely affected First Nations women” (p. 180). Stevenson expresses similar frustrations as she describes the origins of her disillusionment with the feminist movement, which in her
view failed to address Aboriginal women's oppression by colonialism. For these reasons (among others) some Aboriginal women scholars have made an effort to construct a gendered identity distinct from non-Aboriginal women and feminist movements.

Whereas liberal feminism has been concerned with gaining access to existing political structures, some Aboriginal women advocate opting out of the mainstream political structure (Monture Angus, 1995). In part, this stems from concerns that mainstream feminist agendas have not been relevant to the needs of Aboriginal women. Shannon Simpson (2001), then an Aboriginal graduate student in Women's Studies, has observed that when feminist organizations have attempted to incorporate the agendas of Aboriginal women, the focus has generally been on speaking for rather than with Aboriginal women. Thus, the issue of whether to work within or outside the mainstream political structure creates a major source of conflict among Aboriginal women and organizations (Monture Angus).

Aboriginal scholars or activists who do speak from a feminist perspective find themselves in a paradoxical situation. As LaRocque (1997) writes,

When Native women turn to contemporary analysis to explicate their double oppression, they are often accused of using 'white' instead of Native traditions....When Aboriginal women demand justice in a contemporary context, they are accused of betraying 'solidarity,' putting them, in effect, in an absolutely no-win situation between justice and community. (p. 90)

In several cases, feminist perspectives have been critiqued as advancing the goals of individuals (women's rights) at the expense of more pressing collective rights (e.g., land

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38 On the issue of collective versus individual rights, LaRocque (1997) raises some important considerations. She writes: "Native people have had to emphasize collective rights on the issue of land, but it must be remembered that the framework around which Aboriginal rights are pursued originates in European theory and
rights, self-determination, treaty rights) (Jackson, 1994). This claim has been particularly divisive for political organizations such as the Assembly of First Nations (AFN) and the Native Women’s Association of Canada (NWAC) (Fiske, 1996b; LaRocque, 1997). More recently, Aboriginal and non-Aboriginal scholars have pointed to problems inherent in arguing dichotomous positions – individual versus collective, traditional versus non-traditional, feminist versus non-feminist – preferring instead to draw attention to the political agendas that underlie these false dichotomies (Eisenberg, 1998; LaRocque, 1997). For example, according to LaRocque (1997), the AFN has been criticized for dismissing NWAC’s concerns about First Nations women’s issues because they were “under the influence of white feminists (who in turn, are often accused of espousing individual rights as if they exist apart from society)” (p. 87). This has put some First Nations women’s organizations and advocates in the “untenable position of having to choose between gender and culture – as if gender rights were never, or should never be, an issue within Native families, homes, and traditions” (p. 87). Aligning with feminist perspectives has therefore had an alienating effect for some First Nations women, scholars and organizations both inside and outside First Nations communities.

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39 Formerly the National Indian Brotherhood, the AFN is the national representative/lobby organization for the First Nations in Canada (Assembly of First Nations, 2001).

40 Founded in 1974, the NWAC is an aggregate of Native women’s organizations representing status and non-status First Nations and Métis women (NWAC, 2003). Their mission statements is “To help empower women by being involved in developing and changing legislation which affects them, and by involving them in the development and delivery of programs promoting equal opportunity for Aboriginal women” (NWAC). Their focus on constitutional guarantees of self-determination for Aboriginal women and communities has positioned them in opposition to male-dominated federally funded national Aboriginal associations such as the AFN, among others (Fiske, 1996b).
Those Aboriginal scholars who find value in drawing on feminist perspectives emphasize the inextricable links between racism, sexism and patriarchy as legacies of colonial oppression. LaRocque (1993) explains her position in the following way:

Racism has provided justification for the subjugation of Aboriginal peoples. While all Aboriginal people are subjected to racism, women further suffer from sexism....For Aboriginal women, racism and sexism constitute a package experience. (p. 74)

Therese Nahanee (1992) writing about Aboriginal women, justice and the Charter of Rights and Freedoms expresses concern about the extent to which power and control over community life and decisions remain in the hands of predominantly male leaders, placing women in vulnerable positions. Members of NWAC also draw on feminist perspectives to advance their arguments by refocusing attention on the gender-based discrimination perpetrated by the state and within Aboriginal communities (Stacey-Moore, 1993).

Given the extent of cultural and political diversity among Aboriginal peoples, it is unreasonable to expect a unanimous position on the substantive issues concerning feminism and Aboriginal women. There is, however, a common theme running through these diverse positions which focus on the intersecting processes of colonization, racism, economic deprivation and sexism shaping the lives of First Nations women and men. As Simpson (2001) argues, “A feminism that supports Aboriginal women must not only benefit our women, but entire communities” (p. 139). This points to feminist perspectives that move beyond the conventional (liberal) focus on sexual oppression to analyses of intersecting issues within the post/colonial context.

Aboriginal scholars also remind non-Aboriginal women who draw on feminist perspectives to “not forget or ignore their privileged positions...and consciously test their
motives, question their actions and test their attitudes consistently in their relationships with Aboriginal women" (Simpson, 2001, p. 139). I therefore return to the questions set out at the beginning of this section.

In forming my answers, I draw on my experiences working collaboratively with First Nations women on research addressing women’s health (Browne & Fiske, 2001; Browne et al., 2000). Recognizing the tensions that can arise from use of the term feminist theory, and at the request of First Nations women involved in those studies, we reframed these theories as women-centred perspectives guiding our analysis. Tensions did not arise regarding the assumptions underlying the research or its feminist theoretical perspectives; rather, community members favoured the use of a less contentious label for these perspectives. Thus, the theoretical integrity of the project was maintained while respecting women’s recommendations.

In this dissertation, written primarily for an academic audience, I am more explicit in my use of feminist theory. As the study’s findings are translated for distribution within First Nations organizations and communities, and in the practice and policy arenas, the term women-centred may be more appropriate. I also draw on the distinctions between feminist theory as a theoretical lens in inquiry, and feminism as a process of political advocacy in community work. While feminist theories inform the analyses and interpretations arising from this research, my role is not to advocate or impose these perspectives onto the participants, organizations or communities with whom I work. Instead of conceptualizing theory as a way to transform the consciousness of the oppressed (as has been done with some forms of critical theory) (Lather, 1991), “my concern is with what we confront in transforming oppressive relations” (Smith, 1992, p. 96). More specifically, the theory I draw
on provides a lens through which to examine how relations between nurses and First Nations women are shaped by the intertwining processes of colonialism, racism, sexism and classism.

**Theorizing about Racialization, Culture, Difference and Other**

Postcolonial scholarship emphasizes the need for critical analyses of the damaging effects of ‘race’ and racialization while at the same time examining the shifting and inconsistent operations of intersecting oppressions on everyday life (Reimer Kirkham & Anderson, 2002). As constructs of social differentiation, ‘race’, culture, and ethnicity are often used interchangeably and with little consistency to signify difference (often implying inferiority) (McConaghy, 2000; Reimer Kirkham & Anderson). To unravel how complex issues of racism and racialization intersect with issues of culture and difference to influence relations within health care, it is useful to examine the contours of these concepts.

**‘Race’ and Racisms**

The concept of ‘race’ continues to carry profound social significance today as it has in the past (Essed & Goldberg, 2002). As a historically and socially determined construct, ‘race’ reflects shifting ideological and sociopolitical contexts (Harding, 1993). Far from being a neutral descriptive category, ‘race’ continues to be a politically charged and contentious concept that remains symbolic of (among other things) antagonistic relations of power and domination in our society (Krieger & Bassett, 1993). As Harding writes, although ‘race’ is socially constructed, it is “also ‘lived in’...manufactured yet also ‘material’....[T]he fact that racial difference is socially constructed does not prevent it from having real, structural effects in society” (p. 9).

Although the biological basis of racial distinctions has been refuted with the recognition of greater diversity within groups than across groups, ‘race’ continues to provide
the basis for unequal and unjust social relations (Krieger & Sidney, 1996; LaVeist, 2000). To interpret the meaning of race is therefore to define it as an element of social structure – not as an irregularity within it (Omi & Winant, 1986/2002). As they argue,

Everybody learns some combination, some version, of the rules of racial classification, and of her own racial identity, often without obvious teaching or conscious inculcation. Thus are we inserted in a comprehensively racialized social structure. (p. 127)

Racialization, originally conceptualized by Fanon, “assumes that ‘race’ is the primary, natural and neutral means of categorization” and that groups are distinct in behavioural characteristics, which result from their ‘race’ (Ahmad, 1993a, p. 18). Fundamentally, racialization refers to a process of “categorization, a representational process of defining an Other” (Miles, 1989, p.75). As a central concept in this dissertation, racializing processes, policies and practices have been central to the colonial project of defining, categorizing and managing Aboriginal peoples; the consequences remain evident today as health and social inequities, economic marginalization, and enduring negative images and stereotypes are perpetuated.

As the realities of internal colonialism illustrate, issues of ‘race’, racialization and racial formation are inherent in the fabric of Canadian society: they are not processes that we can simply move beyond. As Reimer Kirkham and Anderson (2002) emphasize,

As a constitutive element of our common sense, race is a key component of our taken-for-granted reference schema through which we get on in the world. Individual psyches and relationships among individuals are shaped by race; collective identities and social structures are racially constituted. (p. 4)
Various interconnected forms of racisms have been examined by leading theorists such as Essed (1991, 2002), Essed and Goldberg (2002), Gilroy (1992/2002), Goldberg (1993), Hall (1986/1996a, 1989/1996b), Miles (1989), and Omi and Winant (1986/2002), among others. Neither can be necessarily isolated from the other: as Goldberg (1990) comments “at the most abstract of theoretical levels, all forms of racism may be linked in terms of their exclusionary or inclusionary undertakings” (p. xiv). Nonetheless, it can be useful for discussion purposes to examine how varying racisms overlap and intersect to sustain social inequities and unequal relations of power among and within groups.

In today’s political context, the concept of democratic racism helps to explain how Canadians can hold negative, racialized views of Aboriginal peoples while at the same time espousing liberal principles of equality, tolerance, fairness and justice (Henry, Tator, Mattis & Rees, 2000). Democratic racism is an ideology in which two sets of values coexist yet fundamentally conflict; as such, democratic racism can be difficult to identify and challenge because outward commitments to democratic principles are espoused and frequently conceal discriminatory attitudes (Henry et al.).

Gilroy (1992/2002) views the conflation of culture with ‘race’ as particularly problematic, as it has led to the construction of particular groups as united “exclusively in terms of culture and identity rather than politics and history” (p. 251). By substituting culture for ‘race’, issues of racialization are discussed in less contentious terms. This is a feature of democratic racism: the (ostensible) neutralization of ‘race’ shifts attention away from racism, racialization, gender and class as intersecting processes that disproportionately disadvantage some groups and not others. In the health care arena, as in other dominant institutions, denying or minimizing racialized inequities avoids confrontation with institutionalized and
individual racism, and discounts the connections between structural inequities and disadvantage (Dyck & Kearns, 1995).

In popular discourses, racism is typically understood at an individual level. Critical race theorists emphasize that racist attitudes are more adequately understood as psychological reflections of – and inherently connected to – the ways in which social relations are structured (Henry et al., 2000). Individuals are not located outside of the social relations through which racisms operate (Essed, 2002). In the subsequent chapters, I illustrate how racializing discourses about Aboriginality expressed within health care settings reflect racially structured relations that are (unintentionally) expressed by agents who reflect and reactivate pre-existing social and structural inequities. Thus individual racism may be a contradiction in terms, since, by definition, it involves “the expression or activation of group power” (p. 179).

Despite the “fallacies of ‘institutional’ and ‘individual’ racism” (Essed, 2002, p. 178), the theoretical notion of institutional racism is still useful for understanding how racist exclusions and inclusions are perpetuated within complex systems including health care, academia, the justice system and education. In definitional terms, institutional racism can be understood as “the practices, policies, and procedures of various institutions, which may, directly or indirectly, consciously or unwittingly, promote, sustain or entrench differential advantage or privilege” for certain groups of people (Henry et al., 2000, p. 56). For example, as discussed in Chapter Eight, nurses’ workplaces support processes of institutional racism by failing to challenge taken-for-granted discourses; the consequence is an environment that is permissive of everyday racializing conversations.
Essed's (2002) conceptualization of everyday racism helps to illustrate the fluidity among micro and macro dimensions of racism. As Essed explains:

The everyday is based on expectations and conditions that are taken for granted (p. 187)....Everyday racism is the integration of racism into everyday situations through practices...that activate underlying power relations. This process must be seen as a continuum through which the integration of racism into everyday practices becomes part of the expected, of the unquestionable, and of what is seen as normal by the dominant group. (p. 188)

The concept of everyday racism conveys how racial relations are actualized and reinforced through routine or familiar practices in everyday situations. As I illustrate in the upcoming chapters, without fully realizing it, specific agents – nurses, educators, academics, etc.– become involved in different ways and in varying contexts in the reproduction of everyday racism. Intentionality is not the issue: individuals may not have knowledge about the workings of racialization or other forms of oppression, or of the consequences of their actions (Essed, 1991). Nonetheless, individuals become implicated in socially organized relations of power:

When agents are socialized with and systemically exposed to representations that justify White dominance, and when these notions are (unwittingly) accepted as ‘normal’, agents will act in concert, thereby creating and reproducing similar forms of racism. (p. 46)

Dominant perceptions of Aboriginal peoples represent a case in point, as explained in Chapter Two. Members of the dominant culture have been socialized to accept popularized, negative images of Aboriginal peoples as true representations (Furniss, 1999). As I continue
to argue in the following chapters, these are best understood not as individual opinions, but as reflections of a whole range of historically and politically mediated relations reproduced and reinforced in routine social exchanges.

The Complexities of Culture and Culturalism

As with race, conceptualizations of culture carry a range of meanings (Reimer Kirkham & Anderson, 2002). Margaret Lock (1993), drawing on Raymond Williams' work, notes that culture is one of the most complicated terms in the English language. Far from being transparent, culture is a concept that is exceptionally difficult to define. She traces the shifting meaning ascribed to culture:

During the 18th and 19th centuries the word civility was often used to distinguish educated people who were cultured and enlightened from ‘uncivilized’ peasants. Gradually this usage was transformed into a notion which is still very much with us today: that modern cities and their inhabitants are cultured, where as people who live outside cities are immersed in ‘rural idiocy’. (p. 144)

How we have come to conceptualize culture is therefore historically and politically mediated and influenced by colonial relations.

Today, culture is popularly understood as comprising the beliefs, norms, values and practices that are assumed to be characteristic of particular groups. Liberal notions of respect for cultural diversity, for example, have been taken up as official state policy in Canada and other commonwealth countries (Lock, 1993). On the one hand, acknowledging and celebrating culture has helped to raise public appreciation for the diverse groups within Canada. On the other, postcolonial and critically-oriented scholars remain concerned with the apparent conflation of culture with objectified notions of differences, and with the
proliferation of analyses which overlook culture as inextricably mediated by historical, economic and political conditions.

Locating culture within a relatively static, apolitical set of belief systems provides an entirely different analytical perspective than locating culture within “a complex network of meanings enmeshed within historical, social, economic, and political processes” (Anderson & Reimer Kirkham, 1999, p. 63). In the health care arena, this more complex understanding of culture tends to be overshadowed by essentialist notions of culture as the “lifeways” and “values” of cultural groups (Campinha-Bacote, 1999, p. 204). Knowledge of lifeways and values represents a starting point, however, this tends to be applied in ways that diminish the significance of power relations and structural constraints organizing health and people’s experiences (Meleis & Im, 1999). By focusing on patients’ culture – narrowly defined – the importance of relating wider issues of political economy, racism and marginalization to health care encounters is overlooked (O’Neil, 1989). As Lock (1993) cautions:

One other major concern is that the notion of culture is in danger of being seized on as a panacea, as the key which will open the door to a trouble free health care system, while once again, the deeper more persistent problems which lie at the root of so much ill health, most particularly poverty, exploitation, and discrimination, remain unexamined. (p. 145)

Despite growing concerns expressed about images of the Other reproduced through these discourses, static notions of culture continue to predominate in health care discourses.

Examining the ideology of culturalism provides a framework for understanding the continuities between essentialized notions of culture, ‘race’ and racism (McConaghy, 2000). As a complex practice and ideology, culturalism uses culture as the primary analytical lens
for virtually all health, social, political, economic and educational analyses (McConaghy, 1997). Speaking in relation to indigenous cultures in particular, McConaghy writes:

This indigenous culture that I am referring to is not the culture as lived, but the culture as constituted, as written about and described in ethnographic texts. It is this notion of culture which allows indigenous people to be othered in colonialism....[F]requently these images and stereotypes limit and contain indigenous people and prevent them from attaining material and symbolic gains. In a real sense, these images objectify and de-humanise indigenous people. (p. 83)

Othering refers to the projection of assumed cultural characteristics, differences or identities onto members of particular groups. These projections, however, are not based on real or actual identities; rather, they are founded on assigned, often stereotyped identities. As a result, Othering effectively erases the complex, multiplicities of heterogeneous indigenous identities and experiences in favour of essentializing versions. As a form of racism, Othering is central to establishing and reinforcing unequal social relations. Culturalist discourses, infused with notions of cultural essentialism, operate by assuming and constructing sharp binaries between “Western culture” and particular Other cultures (Narayan, 2000). By “defining the Other (usually as inferior) one implicitly defines oneself against that definition (usually as normal or superior)” (Ahmad, 1993a, p. 18).

Increasingly, culture is used in dominant discourses – and in health care – as a metonym for difference – differences that typically imply inferiority (Reimer Kirkham & Anderson, 2002). Instead of expressing racism directly, “coded signifiers” such as culture or cultural differences are used (p. 5). As Narayan explains, (2000) culturalism and cultural essentialism often operate within discourses of difference “to conceal their role in the
production and reproduction of such 'differences,' presenting these differences as something pre-given and prediscursively 'real' that the discourses of difference merely describe rather than help to construct and perpetuate” (p. 82). For example, it is not uncommon to equate the culture of Aboriginal peoples with the cultures of poverty, substance abuse and dependency. These images, as I have argued, are deeply embedded in the consciousness of most Canadians. Since 'race' is no longer an acceptable context in which to discuss popularized mis/representations of Aboriginal peoples, these enduring images are discussed as cultural attributes or differences. Herein lies the danger: by conflating culture with racialized characteristics, the discriminatory significance of cultural characteristics becomes hidden behind more acceptable, neutralized terminology (Goldberg, 1993). Through culturalism, the racialized Other becomes normalized and naturalized (McConaghy, 2000).

**Cultural Safety as a Theoretical Lens for Analyzing Health Care Interactions**

In the postcolonial climate of Aotearoa/New Zealand, “cultural safety” has developed as an alternative to culturalist discourses in health care. Unsatisfied with transcultural nursing theories and concepts, Maori nurse leaders developed cultural safety as a theoretical construct for addressing historically and politically mediated power relationships in health care (Ramsden, 1993, 2000). Developed in collaboration with Maori people, cultural safety extends analyses well beyond culturalist notions of cultural sensitivity to power inequities, individual and institutional discrimination, and the dynamics of health care relations in the postcolonial context (Papps & Ramsden, 1996). Ultimately, cultural safety is concerned with changing attitudes and with gaining an awareness of the political and historical forces shaping health care interactions with Aboriginal peoples. Rooted within postcolonial theory,
cultural safety provides a critical lens through which to examine health care interactions in this dissertation.

By calling for the transformation of deeply ingrained relations or power, paternalism and authority in health care, cultural safety provides a more radical framework than does cultural sensitivity (Kearns & Dyck, 1996). The concept is intended to mitigate cultural risk for indigenous peoples, defined as a “process whereby people from one culture believe that they are demeaned, diminished and disempowered by the actions and the delivery systems of people from another culture” (Wood & Schwass, 1993, p. 20). Rather than presenting a set of guidelines for how to convey cultural safety, the process and outcome of cultural safety aims to recognize and reflect indigenous worth in health care provision (Reimer Kirkham et al., 2002).

Cultural safety represents an unequivocal call to nurses to analyze mis/representations of indigenous peoples, racialization, and notions of cultural differences in ways that make visible their historical situatedness (Reimer Kirkham et al., 2002). Recognizing the potential for cultural safety to cultivate a shift in nurses’ attitudes toward Maori people, the New Zealand Nursing Council requires that 20% of the national registration examination include content related to cultural safety; nurses must study, for example, the Treaty of Waitangi, the distribution of power within Aotearoa/New Zealand, and issues of ‘race’ relations and structural racism (Dyck & Kearns, 1995). Nurses are therefore required to study the historical, political and social structures that continue to subordinate and marginalize Maori people (Ramsden, 2000). Not unexpectedly, there has been considerable resistance and, in some cases, backlash within the health care and public domains (Ramsden, 2000). Public controversy has focused on “the idea that there had been a take-over of such a trusted body as
nurses and that their education was being manipulated by Maori,” and that “teaching such matters as the Treaty of Waitangi and the health and disease outcomes of colonisation were irrelevant to nursing” (p. 6). Despite these ongoing controversies, cultural safety remains a basic requirement of nursing registration in New Zealand (Nursing Council of New Zealand, 2002).

Cultural safety is now drawing international attention. In Canada, several nurse-researchers are applying the concept to examine health care involving various marginalized groups including Aboriginal patients (Anderson, 1998a, 2001; Anderson et al., 2003; Browne et al., 2000; Browne & Fiske, 2001; Reimer Kirkham, 2000; Reimer Kirkham et al., 2002; Smye & Browne, 2002). Despite significant distinctions between the colonization process in Canada and New Zealand, the core assumptions underpinning cultural safety indicate that colonial practices and attitudes manifested in health care cross geographical and political boundaries (Reimer Kirkham et al.).

**Summary**

Perspectives drawn from postcolonial feminist theories provide the interpretive lens through which I approach this research. Cultural safety, with its attention to historical power relations, helps to focus my gaze on the dynamics of nurse-patient interactions. Together, these theoretical perspectives are used to critically examine (a) the taken-for-granted assumptions about ‘race’, culture and difference shaping nurses’ views of Aboriginal women, (b) routine interactions between First Nations women and nurses as they are located within a wider historical and postcolonial context, (c) women’s interpretations of their health care experiences, and (d) racializing discourses within the institutional environment.
The risk inherent in applying these perspectives is in predisposing researchers to focus on some aspects of the data and not on others (Reimer Kirkham, 2000). To counter these tendencies, my goal has been to apply theory as an interpretive lens without the theory becoming “the container into which the data must be poured” (Lather, 1991, p. 62). As I explain in Chapter Four, engaging critically with theoretical perspectives and maintaining an ongoing process of reflexivity are therefore central to conducting the research.
CHAPTER FOUR
RESEARCH DESIGN AND IMPLEMENTATION

Introduction

The theoretical perspectives informing this research, the methodology guiding implementation, and the methods for collecting data should fit together to create a congruency of logic within the research process (Crotty, 1998). This chapter focuses specifically on how the research process was conducted. I begin with the methodology guiding the research, defined by Sandra Harding as "a theory and analysis of how research does or should proceed" (1987, p. 3). In this study, Dorothy Smith's (1987, 1992) standpoint perspective was used as the method of inquiry or methodological orientation framing the research. After discussing the principles and assumptions underlying Smith's standpoint perspective, I describe the research design, the research participants, and the techniques used for gathering data, namely, observations of nurse-patient interactions and in-depth interviewing. Data analysis procedures and criteria for evaluating the scientific rigour of the research are then reviewed. The chapter concludes with a reflexive analysis that attempts to make transparent how my social location shaped the process of research.

Method of Inquiry: Dorothy Smith's Standpoint Perspective

The critical foundations of Smith's (1987, 1992) method of inquiry, drawn from historical materialism and socialist feminism, provides a theoretically congruent link between the theory I draw on and the methodology I employed. As a method of inquiry, standpoint perspective\(^4\) provides "a method both of thinking about society and social relations, and of

\(^4\) Smith's conceptualization of 'standpoint' differs from that of feminist standpoint theorists such as Harstock (1983), Harding (1986), Collins (1991, 2000). One central difference is Smith's interest in explicating the social relations of knowledge versus developing knowledge from women's perspectives (Mann & Kelley, 1997;
doing research” (Smith, 1992, p. 91). The terms “social relations,” “social organization,” and “socially organized” do not refer to individual relationships; rather, social relations refer to “concerted sequences of courses of social action implicating more than one individual whose participants are not necessarily present or known to one another” that “nonetheless enter in and organize” experiences (Smith, 1986, p. 7). Inquiry informed by Smith’s standpoint perspective therefore aims to show “how our everyday worlds are hooked into and shaped by social relations, organization, and power beyond the scope of direct experience” (Smith, 1992, p. 89).

Methodologically, Smith’s standpoint perspective directs us to begin inquiry “in the actualities of people’s living, beginning with their experience of living” (Smith, 1992, p. 90). People’s experiences thus provide a standpoint (Campbell & Manicom, 1995). Beginning research in people’s everyday experiences does not grant epistemological privilege to subjective perspectives or reify subjective experiences as fact or truth. In fact, Smith steers us away from social inquiries based on individuals’ subjective interpretations of their experiences (Mann & Kelley, 1997). Instead, by assuming that experiences cannot be understood outside of social relations, the purpose is to link people’s experiences to the larger social relations that organize their experiences.

Smith’s methodology does not imply that there is a common standpoint among women, be it First Nations women or health care providers. Recognizing the heterogeneity of people’s experiences, different sites of experience (or different standpoints) bring into focus “different social relations or different aspects of the same complex” (Smith, 1992, p. 91). The goal, therefore, is to use experience as the entry point – a window – into the workings of
social relations, "to see how experience is (or is shaped up to be) inextricably bound to regimes of ruling"\textsuperscript{42} (Smith, 1990, p. 9).

A key assumption in Smith's standpoint perspective is the socially constructed nature of knowledge and experience: "Since knowledge is essentially socially organized, it can never be an act or an attribute of individual consciousness" (1992, p. 91). Inquiry begins with the subject/knower who is materially, historically, culturally and socially located. The aim is then to explore and explain the actual social processes and practices organizing people's everyday experiences (Smith, 1986). As Campbell (1998) explains: "Experiential data, whether from interviews or observations, thus inform a method, allowing researchers an entry to social organization for the purpose of explicating the experiences; by explication I mean to write back into the account of experiences the social organization that is immanent, but invisible, in them" (p. 60).

Applied as the method of inquiry guiding this study, inquiry began with observations of nurse-patient interactions in hospital, and interviews with nurses and First Nations women who described their experiences interacting with each other. Taking the experiential perspectives of nurses and First Nations women as starting points for inquiry, the aim of my analysis was to examine the ways in which nurse-patient interactions are socially organized by wider historical relations, current Aboriginal-state relations, dominant ideological viewpoints, nurses' professional knowledge, and other socially mediated factors. The goal was not to generalize nurses' or women's experiences but to link particular, local experiences

\textsuperscript{42} Smith (1987) explains ruling relations or ruling apparatus as those intersecting organizing practices of educational, legal and economic institutions, and "that familiar complex of management, government administration, professions, and intelligentsia, as well as the textually mediated discourses that coordinate and interpenetrate it" to form a network of social relations (p. 108).
and perspectives into wider “generalized and generalizing” social relations (Smith, 1987, p. 147).

**Research Design**

To meet the research objectives situated within a postcolonial feminist framework and guided by Smith's standpoint perspective, the research design and methods needed to: (a) allow for direct observation of interactions between nurses and First Nations women, (b) elicit nurses' and women's descriptions of their interactions with each other, and (c) provide analytical insights into how nurse-patient relations are influenced by wider institutional and social contexts. A qualitative design incorporating observations of nurse-patient interactions and in-depth interviews with nurses and First Nations women best met these requirements.

**Research Setting**

The setting for this study was a hospital located in a northern BC city. A hospital was selected as the research site because it represents a key environment in which nurse-patient interactions occur, and because nurses have contact with patients 24 hours a day. The research activities were carried out on several different areas, including for example, medical, surgical, and postpartum wards, and an outpatient clinic. Due to current staffing shortages in the emergency department, nursing administrators requested that the study not be conducted there. I was, however, employed as a practicing nurse in the emergency department on a casual basis throughout the duration of the study. Although my clinical and research roles were completely separate and no data were collected in the emergency department, inevitably, my experiences in emergency provided contextual knowledge concerning the types of patients using the emergency department, nursing workload issues, and the overall institutional environment.
The hospital serves populations residing in a wide geographic area, including urban, rural and remote communities. First Nations people in these regions comprised 7-20% of the total population in 1996, compared to an average of 3.8% in BC (BC Statistics, 2003). To maintain anonymity, the hospital is not identified.

As a permanent resident in the city where the hospital is located, I was familiar with the local health care scene and some of the First Nations communities and leaders in the region. Although I had conducted research in partnership with local First Nations communities and organizations, those studies addressed community-level health care services. I had not undertaken prior research or had any significant contact with the hospital. As a nurse and an academic, however, I knew several hospital nurses and nursing administrators. As I discuss later, this provided a certain ease of access into the hospital and facilitated rapport with some of the nurses.

As the study was conceptualized, I discussed the purpose and methods with several First Nations leaders. I was particularly interested in obtaining their feedback concerning the study’s design and the proposed involvement of First Nations community members as participants. As the study took shape in the form of research proposal, letters of support were sought and received from the local Friendship Centre, the regional Tribal Authority, and leaders within the local First Nations health care sector. The Medical Officer of Health for the region also provided a letter of support for the study.

Gaining Access

Negotiating entry to the hospital was initiated through discussions with the hospital’s senior nursing administrator, who, although serving in an acting position, was keenly committed to promoting nursing research throughout the institution. (Until recently, very few
nursing studies had taken place in the hospital). In turn, she directed me to a nursing manager who sat on the hospital’s research review committee. As a nurse-manager, she was able to discuss the feasibility of the study’s design and proposed involvement of nurses and patients. In turn, I met several other nurse-managers who were responsible for nursing services on other hospital wards. Based on their collective feedback, minor modifications were made to the procedures for recruitment of participants. They also determined which units would be best suited for the observational procedures I proposed. Based on their assessment, particular units were eliminated as study sites, due primarily to nursing staff shortages and in consideration of the emotional and physical vulnerability of patients and families in high acuity areas of the hospital (e.g., the intensive care unit, and the labour and delivery unit).

The nurse-managers were instrumental in negotiating my access into particular wards: each took responsibility for informing the wards’ nurse-in-charge (or charge-nurse) of the study in very general terms. The charge-nurses were therefore aware of my purpose in approaching them about potential research participants. In response, the charge-nurses reviewed their patient and staff rosters with me with a view to identifying possible participants.

**Sampling Strategy**

In this kind of research, the goal was not to show the effect of an independent variable on a dependent variable or to examine nurse-patient interactions under controlled situations. Rather, the goal was to explicate the historical and sociopolitical contexts shaping women’s and nurses’ experiences and ways of interacting. Probability sampling was therefore inappropriate for this research design. Instead, purposeful and theoretical sampling of First Nations women and nurses was used. In purposeful sampling, participants are chosen
according to the needs of the study, in this case, First Nations women in the hospital and their nurses.

After a significant proportion of data were analyzed, theoretical sampling was also used to explore relevant concepts and insights arising from the data with particular participants (Thorne, Reimer Kirkham & MacDonald-Emes, 1997). For example, after analyzing data from several Euro-Canadian nurses, I interviewed a First Nations nurse whose perspective differed radically from her colleagues. Although not initially planned, theoretical sampling was used to recruit four additional First Nations nurses (four RNs and one LPN) for interviews, to explore their perspectives and gain a better understanding of the basis of differing professional and personal viewpoints. Theoretical sampling was also used near the end of the study to interview a health care administrator who was involved in planning services for First Nations people in the region. Her perspectives were sought in relation to the study’s preliminary findings, and in particular to gain a sense of whether or not these resonated with her understanding of wider issues influencing health care for Aboriginal women in the hospital.

Sandelowski (1995) has found that data from 15 to 20 people – sometimes less – can be sufficient to provide a comprehensive understanding of a phenomenon under study. In this study, the sample of participants (by group) consisted of 16 registered nurses (RNs) and 2 licensed practical nurses (LPNs), 12 women who were patients at the hospital, 2 of their support persons, 1 community health representative, 1 Aboriginal Support Worker, and 1 health care administrator, for a total of 35 ($N = 35$) participants.

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43 One of these support persons was the sister of a patient and both were involved in observational sessions and interviews. The second support person was a close friend and caregiver of a patient, and participated in an interview with the patient in the patient’s home.
The inclusion criterion for nurse-participants was designation as a RN, with two exceptions made to theoretically sample two First Nations LPNs as interview participants. One of these LPNs was sampled because of her long-standing history of employment as one of the few First Nations nursing staff members in the hospital. The second LPN, who was close to completing her baccalaureate of science in nursing (BSN) degree, was also interviewed to gain her perspectives as a First Nations nurse working within the hospital. All nurses who participated in formal observational sessions, however, were RNs in order to maintain consistency in terms of the nature of nursing care observed. As the data are presented, the terms RN and LPN are used to distinguish one from the other.

The inclusion criteria for patient-participants were: (a) self-identification as Aboriginal, (b) age 18 or over, (c) English speaking (which includes the vast majority of people in this region), (d) no known cognitive impairment, and (e) those whose health status would not be affected by participating.

Recruitment of Participants

Recruitment of patient-participants was in most cases initiated by a ward’s charge-nurse (who on evenings/nights and weekends was a designated nurse-in-charge). After reviewing the range of patients present on the ward (usually by glancing through the patient roster), the charge-nurse identified patients who met the inclusion criteria. Since patients are not asked to disclose their ethnic or cultural identity (only religious affiliation is noted on admission), the charge-nurse drew on her intuitive knowledge to determine who might be of Aboriginal descent. This highlights a paradox inherent to this study: how to identify potential First Nations research participants without engaging in the objectifying and racializing process of guessing who may be First Nations. Most likely, charge-nurses made this
determination on the basis of appearance, or from the patient's home address (e.g., whether the address included the name of a reserve community). Recognizing this as a limitation, it was by necessity a process that was largely unavoidable. In addition, at the start of the study, two First Nations women were also identified by the Aboriginal Support Worker as potential participants. (As the study proceeded, the Aboriginal Support Worker was absent for several months, and upon her return, was overburdened with work. She therefore was no longer available to participate in the recruitment of patients).

Once a potential patient-participant was identified, the charge-nurse introduced me to the RN who was assigned to the patient. At that point, either the charge-nurse or I introduced myself to the RN. Nurses who were approached to participate were given a verbal explanation and an informational pamphlet explaining the nature of the study, after which they made their decision to participate or not (pamphlets for nurses and patients are located in Appendix A).

Before seeking the RN's written consent, I discussed the inclusion criteria for patients with the RN, who then proceeded to introduce me to the patient. I then provided patients with a brief explanation of the study and an invitation to hear more details. Those women who expressed interest were provided with a more detailed account of the study and the process of consent. I also reviewed an information pamphlet prepared for patients as a way of leaving a more permanent, tangible record of the study. (These pamphlets turned out to be useful devices; on several occasions, I observed women showing the pamphlet to their visitors, who in turn discussed the study with me). In some cases, I read the pamphlet and consent form out loud to women (some of whom asked me to), particularly if I felt a woman was encountering difficulty reading these herself. Nurses' written consent was obtained after determining
whether or not their patient consented. Finally, the Aboriginal Support Worker, the community health representative and the health care administrator were recruited by me after explaining why I sought their participation. (All consent forms are located in Appendix B.)

**Overview of Participants**

**First Nations Women Participants (n=14)**

The demographic profiles of the 12 patients and 2 support persons who participated in this study are listed in Table 1. Thirteen of 14 women participated in both observational sessions and interviews (one support person was not present for the observational session and therefore participated in an interview only). All of the women self-identified as First Nations and were either born or raised in reserve communities in northern regions of BC or Alberta. At the time of the study, eight women resided off-reserve in the city, and six lived on reserves in the surrounding region.

The ages of the women varied widely from 19 to 73, though the majority (N=9) were over age 40. Educational levels also varied widely: one woman was in the process of completing a university degree, and four had taken some college or university courses. Eight had not completed high school, including three women who had no conventional formal schooling. Of the 11 women who were under 65 years of age, 4 were employed either full-time or part-time; other than 1 full-time university student, the remaining women were either unemployed or retired (though most worked within their homes parenting children). Two of the women made explicit reference to living in impoverished conditions. Six were single-mothers and four women were actively parenting extended family members' children within their homes on a full-time basis. Reasons for their current admission to the hospital included
elective or emergency surgeries, management of acute and chronic conditions, and prenatal complications.

**Nurse Participants (n=18)**

As illustrated in Table 1, all of the non-First Nations nurses were of Euro-Canadian descent. The remaining six nurses self-identified as First Nations. To distinguish the two groups of nurses, I have retained these categorical labels, despite their essentialist and homogenizing connotations. The term White is the more common colloquial term used in Canada to distinguish non-Aboriginal peoples, however, Furniss (1999) suggests that Euro-Canadian is "the accepted term in formal academic discourse to refer to the dominant segment of Canadian society" (p. xi). Extending Furniss' rationale, I also 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). Theoretically, then, the terms Euro-Canadian and White can be used interchangeably; however, when referring specifically to the White nurses who participated in this study, the term Euro-Canadian is used.

Most of the First Nations and Euro-Canadian nurses were employed full-time in nursing and those in casual positions worked near full-time hours. Of the 16 RNs who participated, 3 were BSN prepared and 13 were diploma prepared. Among the diploma prepared RNs, two had BSNs in progress, and one had a social work degree. One of the LPNs was near completing her BSN degree. Most of the nurses were also very experienced. For example, seven had 21 or more years of experience working as an RN or LPN, and over half had worked for over 10 years. Only two had worked as nurses for two years or less.
Table 1: Socio-Demographic Characteristics of Study Participants (N = 35)

<table>
<thead>
<tr>
<th>Participants¹</th>
<th>Ethnicity</th>
<th>Country of Birth/ Linguistic Group²</th>
<th>Age</th>
<th>Employment Status</th>
<th>Highest Educational Attainment³</th>
<th>Years Employed as RN/LPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses⁴ (n = 18)</td>
<td>First Nations 6</td>
<td>Canada 15</td>
<td>19-30</td>
<td>Full time</td>
<td>RN, Diploma⁷ 13</td>
<td>0-2 2</td>
</tr>
<tr>
<td></td>
<td>Euro-Canadian 12</td>
<td>Other³ 3</td>
<td>31-40</td>
<td>1</td>
<td>RN, BSN 3</td>
<td>3-5 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>41-50</td>
<td>5</td>
<td>Retired 4</td>
<td>11-15 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-60</td>
<td>5</td>
<td>Full time 18</td>
<td>16-20 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>61+</td>
<td>0</td>
<td></td>
<td>21-25 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>26-35 4</td>
<td></td>
</tr>
<tr>
<td>First Nations Women (n = 14)</td>
<td>Babine-Witsuwit’en 1</td>
<td>19-30</td>
<td>3</td>
<td>No formal 3</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dakelh (Carrier) 8</td>
<td>31-40</td>
<td>2</td>
<td>Elementary 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dene-thah (Slave) 2</td>
<td>41-50</td>
<td>2</td>
<td>Secondary 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cree 1</td>
<td>51-60</td>
<td>4</td>
<td>Some Tertiary 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gitksan 2</td>
<td>61-70</td>
<td>2</td>
<td>College 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>71-80</td>
<td>1</td>
<td>University 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Three participants (one health care administrator, one Community Health Representative, and one Aboriginal Support Worker) were also interviewed to provide contextualized data.

² Aboriginal peoples’ linguistic groupings reflect cultural identities.

³ Maximum level completed: thus, ‘secondary’ equates to a completed high school diploma, ‘some tertiary’ refers to one or more college and/or university courses taken, ‘college’ refers to completion of a college diploma, and ‘university’ refers to a completed university degree.

⁴ Includes 16 RNs and 2 LPNs.

⁵ These nurses were either born in the United States or Europe.

⁶ Among the diploma-prepared RNs, two were completing BSN degrees and one had a baccalaureate degree in social work.

⁷ One LPN was in the process of completing a BSN degree.

⁸ ‘Unemployed’ refers to the absence of paid employment outside the home; however, ten women were actively involved in parenting children within their homes.
Other Participants (n=3)

The Aboriginal Support Worker interviewed in this study had worked for many years in health care before taking up her full-time position in the hospital several years ago. The community health representative who participated in an interview has been employed in a rural reserve community for almost 20 years. The health care administrator interviewed was a First Nations person who had been employed in the health and social services field in First Nations communities for many years.

Data Collection Methods and Procedures

Consistent with the research design, two ethnographic methods of data collection were used: (a) observations of nurse-patient interactions in the hospital, and (b) in-depth, open-ended interviewing with nurses, First Nations women, the Aboriginal Support Worker and the health care administrator. Both observation and in-depth interviewing are well documented in the research literature as rigorous methods for collecting rich, contextualized data (Spradley, 1979, 1980; A. Williams, 1996).

Observations

Observations of nurse-patient interactions provide valuable perspectives because the accounts that people construct about how they interact may differ from what happens in the actual encounter (Anderson, 2001). Observations of interactions were conducted by accompanying a registered nurse on a hospital ward for three to four hours as daily care was provided to patients who included First Nations women. Both the nurse and the First Nations woman who was her patient had to provide written informed consent prior to participating in the observational session. Nurses who consented therefore served as my

44 My role as an observer was intentionally not that of a participant observer, which would have required me to engage in the clinical practice of nursing while simultaneously assuming the role of researcher.
guide during the observational session. Observations were limited to three to four hours per shift so that observational concentration could be maintained with accuracy (Reimer Kirkham, 2000). To observe activities and interactions that varied according to time of day, observations were conducted on day and evening shifts (which extended into the nighttime hours\textsuperscript{45}), and on a variety of wards.

To explain my purpose to nurses, other staff, patients and visitors, and to provide a context for seeking out nurses assigned to First Nations women, I identified myself as a nurse-researcher who was there to observe cross-cultural nursing care. To prevent slippage between my role as a researcher and my qualifications as a nurse, I made it clear that my role during observational sessions was not as a practicing nurse. However, as a clinician, I often alerted nurses to changes in patients' status, and assisted nurses with non-clinical tasks such as bed-making, bringing dressing supplies or other equipment. In relation to patients, I often brought tea, ice-chips or water if permitted, adjusted the heads of their beds if requested, or discussed 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 opinions as they engaged in clinical decision-making, to which I responded based on my clinical expertise. As I explain below, these exchanges also indicated that I held an insider status as a nursing professional, which in turn resulted in a certain ease of interacting with the nurses involved in the study.

As I accompanied the nurses, the focus of observations was on interactions between the nurses and First Nations women who consented to participate in observational sessions. Specifically, observations focused on the verbal and non-verbal communication between

\textsuperscript{45} Evening shifts extended until 11:30 p.m. Observational sessions were not conducted during night shifts because of the minimal contact that nurses normally have with relatively stable patients overnight.
nurses and First Nations women, their conversational patterns, and processes of relating and decision-making. The intent was not to evaluate the adequacy or appropriateness of nurses' interactions or practices, but to use observations of interactions as an entry point to inquiry. Observations that carried a high risk of intruding on the patient's sense of vulnerability or privacy were not pursued. For example, when personal care involved exposure of women's bodies, I left the bedside. In other situations, I remained present, for example, during a catheterization as I supported the patient in a face to face position while the nurses conducted the procedure. In this instance, and in others where patients were extraordinarily vulnerable, I drew on my clinical judgment (in consultation with the nurse and patient) to determine whether or not it might be appropriate to remain at the bedside, and in what capacity; in this respect, my role was fluid at times as I moved from a third-party observer to patient-supporter to nurses' helper.

As I accompanied the nurse for three to four hours, I was inevitably present during the nurse's interaction with other patients (i.e., patients other than the First Nations women who consented to participate in observations and interviews). While observations of interactions with other patients were not the primary focus of the study, observing the nurse as she worked with a variety of patients enabled me to examine interactions in the wider context of nurses' everyday work, and provided important points of comparison. For this reason, and with the verbal permission of the patients assigned to the nurse, I observed the nurse as she cared for these other patients. Again, I was judicious about what I observed, and what I absented myself from. In seeking verbal permission from these patients (and their visitors), I provided a brief explanation of the study, which included a clear explanation of their right not to have me present as the nurse interacted with them. To be clear, demographic
information, interviews or other forms of data were not collected from these patients; rather, my attention was focused on the nurses' interactions.

Similarly, observing the nurse interacting with other hospital staff provided important contextual data. Throughout the observational session, I followed the nurse as she completed her charting at the nurses' station, engaged in discussions with other nurses and staff, attended shift reports, or took coffee or meal breaks. These observations provided me with a sense of the informal dialogues that occur among nurses and other staff and the institutional milieu. At the outset of my observational shift, all staff were made aware of my purpose on the ward and the nature of the study through verbal explanations and through informational pamphlets posted on the wards. Typically, nurses and other hospital staff (including, for example, physicians, physiotherapists, pharmacists, social workers and unit clerks) expressed interest in the study. For example, they asked questions about the study or commented favorably about the need for nursing research at the hospital.

Recording Observational Field Notes. Observational data were recorded as field notes, which were essential to the development of detailed accounts of nurse-patient interactions and the institutional context. During observational sessions, field notes were written in short form to facilitate recall immediately after the observational sessions, when field notes were written in full detail. Following organizational procedures that I have used in previous research (Browne, 1995, 1997), field notes were recorded as "observational notes" (descriptive accounts of my observations as a third-party observer), "methodological notes" (notes to myself on the research process, questions for follow-up, angles to pursue in subsequent observations), "theoretical notes" (notes linking observations to literature and theoretical insights), and "reflexive notes" (e.g., reflections on how my own professional and
social positioning may have influenced the research process, participants' reactions to me, and the dynamics of my relationships with participants). Issues and insights arising from these kinds of reflexive analyses on the research process are discussed in more depth at the end of this chapter.

**In-depth Interviews with Nurses**

In-depth interviews with nurses who participated in observational sessions were conducted to explore nurses' experiences interacting and caring for First Nations women. All eighteen nurses participated in at least one face-to-face in-depth interview lasting one to two hours. The majority of nurses elected to hold these primary interviews on their days off and chose to meet me at my research office. For convenience, one nurse chose to be interviewed in a meeting area at the hospital, and two others requested that interviews be held at their homes.

In addition, follow-up interviews were held with four nurses to clarify and verify information discussed in the first interview. Opportunities for informal follow-up discussions also occurred as I spoke with nurses at the hospital during coffee breaks, shift changes or meal times. During these moments, our conversation often steered toward our previous interview and nurses frequently commented on content we had previously discussed or provided additional perspectives.

I conducted all interviews, except for two nurses who were interviewed by a trained, experienced research assistant who was employed to assist with the initial stages of data analysis. Interviews with these two nurses occurred after the research assistant was given clear direction about questions to pursue based on my observational session (which were not necessarily included on the basic interview guide). Due to other commitments, however, this
research assistant was unable to share the interview workload. I therefore completed all remaining interviews.

The in-depth, unstructured interviews were guided by a set of preplanned trigger questions posed by the researcher (all interview guides are located in Appendix C). Subsequent questions were formed during the interview in response to nurses' accounts of their experiences (Spradley, 1979). Interviews always occurred after the observational sessions; additional questions specific to the observational session were also posed, permitting me to discuss my impressions, questions, or insights with the nurse. Several nurses expressed appreciation at the opportunity to discuss specific aspects of their work with me, commenting that it was "a relief" to talk about their nursing practice with me, or that it was "interesting" to think back on specific aspects of their practice. With permission, all interviews were audio-taped and later transcribed verbatim. On two occasions, nurses asked for the tape recorder to be turned off in mid-interview because of the sensitive nature of the content discussed, which indicated to me that they were fully aware of their rights as research participants. Field notes were also recorded after each interview using the format described above for observational data. These helped me to process contextual, methodological, theoretical and reflexive insights related to the interview process. A thank you card and small honorarium was provided to each nurse as a token of appreciation for the time and effort they devoted to the project.

Informal and In-depth Interviews with Patients

Interviews with First Nations women who participated in observational sessions were conducted to explore how women experienced their hospitalization and their interactions
with nurses. All women who consented to participate in observational sessions also consented to be interviewed and I conducted all interviews.

Previous research has indicated that many patients in hospital are reluctant to speak in any depth about their hospital experiences, and that they are more comfortable discussing these experiences in their home environment (Anderson, 1998a). The process of interviewing patients therefore proceeded over two stages. First, while women were in the hospital, I spent time visiting with them (and often their visitors) at the bedside. During these informal visits, women often discussed their home communities, personal circumstances or family life. Depending on their energy level, acuity, and interest, these visits ranged from a few minutes to an hour at a time. Most often, the women and I spent time quietly talking and sipping tea or ice water. Data gathered from these informal discussions were recorded as field notes in the manner described above.

As the study proceeded, it became clear that the rapport developed at the bedside carried over into the subsequent interview conducted after the women were discharged home. The in-depth interviews became extensions of our informal hospital visits. The bedside visits were therefore critical to the interview process as the women and I gained familiarity with one another, our styles of relating, and the dynamics of our discussions.

As with the nurse-participants, all in-depth interviews occurred after observational sessions were completed. Nine of the fourteen women were interviewed in their homes, which were located in the city and in reserve communities up to two hours away by car. The remaining five women were unable to be interviewed at home for a variety of reasons. Two women (sisters who were interviewed together) were from a remote fly-in reserve community; their subsequent in-depth interview was held in a private area of the hospital
cafeteria when they returned for a follow-up examination several weeks after their initial hospitalization. One woman was from a remote community that was difficult to access by vehicle in the winter months; she was therefore interviewed in hospital the day before her discharge. Two women requested that I not attempt to visit them at home, and indicated that it would be unlikely that I could contact them after discharge. I therefore interviewed both of these women while they were in hospital just before they were discharged.

As with the nurses' interviews, in-depth interviews were unstructured and guided by trigger questions. Additional questions were formulated based on observational perspectives, and in response to the dynamics of our conversation. Again, a thank you card and small honorarium was provided to each woman as an expression of appreciation for their time and effort. Providing this type of honorarium is considered to be an appropriate exchange for research participation in many First Nations communities in the region.

**In-depth Interviews with Other Participants**

The Aboriginal Support Worker, the health care administrator and the community health representative each participated in one in-depth interview to gain their perspectives on issues that First Nations women face in hospital. These interviews were also unstructured and guided by trigger questions. The community health representative was interviewed during a joint interview with two RNs who suggested that she be involved. To summarize, the multiple forms and sources of data obtained in this study provided detailed and rich information concerning the patterns and context of interactions between nurses and First Nations women.
Data Analysis

An interpretive thematic analysis was completed using processes described for qualitatively derived data (Anderson, 2001; Huberman & Miles, 1994; Sandelowski, 1995). In ethnographic work such as this, the stages of analysis do not proceed in a linear fashion. Rather, data collection and analysis occur concurrently (Sandelowski). The following steps highlight the analysis procedures though these do not imply a sequential process. Step 1: As interview and observational data were collected, they were transcribed and checked by a research assistant for accuracy against the taped recordings. Step 2: As data were continually gathered, whole interviews and observational field notes were read repeatedly to identify recurring, converging and contradictory patterns of interaction, key concepts, preliminary themes, illustrative examples from the data, and possible linkages to theory. As data were reviewed, preliminary concepts and themes were developed and used to categorize and code the data. As more data were collected and reviewed, coding categories were revised, collapsed or expanded, and refined. Step 3: All data were coded by me. In addition, randomly selected interview transcripts were also independently coded by two trained research assistants in order to compare areas of similarity and differences. Discrepancies in coding led to further refinement of the coding categories and identified areas for further exploration. Coded interview transcripts and accompanying field notes, which comprised the largest component of data, were entered into NVivo®, a software program for organizing and grouping data into sets, which can then be quickly and easily linked, contrasted, compared and retrieved. Step 4: As more data were coded, categories were expanded and/or collapsed, making the analysis an evolving, dynamic process. Critical questioning of theoretical perspectives, my own reflexive analysis, and continual reconsideration of participants'
perspectives resulted in ongoing refinement of coding categories, concepts and themes. This step also included further theoretical sampling of First Nations nurses to explore additional angles of analysis. Step 5: Exemplars from coded categories and themes were retrieved using NVivo and compared within and across transcripts. Concurrently, the interview data were continually read in light of the observational data, which provided important contextualizing information. In the process, my analysis shifted to a more abstract level of conceptualization to generate broader theoretical constructs or propositions.

Ideally, the analysis process includes opportunities for participants to review the researchers' interpretations, so that descriptive and interpretative validity can be checked, and participants can have input into how data are constructed and presented (Thorne et al., 1997). In this study, this step was not formally established with nurses or patients. Instead, near the end of the ten month data collection period, I took the opportunity to discuss my evolving concepts, categories and themes with four nurses and two patients during interviews. I also had in-depth discussions about my developing conceptualization of the findings with the Aboriginal Support Worker and the health care administrator, who were later interviewed. However, a limitation of this study was the lack of a more concerted effort to bring the analysis back to participants. In part this was a function of time constraints and of my need to draw some boundaries around the scope of the dissertation. Thus, the process of reciprocity incorporated into this study – the “mutual negotiation of meaning” – was constrained (Lather, 1991, p. 57). Nonetheless, the insights and feedback I gained from the

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Committing to reciprocity is one way for researchers to avoid imposing theoretical and interpretive perspectives that may not resonate with participants' perspectives. Instead, the goal is “dialectical theory building” whereby researchers move analytically between the data and theory so that there is a reciprocal relationship between data, participants, and theoretical perspectives (p. 61). Consistent with Smith's (1992) standpoint method of inquiry, this approach to analysis allows the researcher to move from the experiences of people to the exploration of the wider social processes that organize experiences.
eight participants I consulted helped me to reconsider and reexamine my ideas as I moved toward more abstract levels of conceptual analysis.

To summarize, the outcome of the analysis was “a statement about a set of complex interrelations rather than the examination of discrete variables” (Anderson, 2001, p. 12). Throughout, an auditable decision trail of analytical and interpretive pathways was maintained. Analysis continued until a synthesized account of the social, political and cultural context of relations between nurses and First Nations women was developed.

Consistent with Smith’s (1992) standpoint perspective, taking the experiences of nurses and patients as the starting point for inquiry does not limit the findings to the local setting. Rather, these experiences should be conceptualized as a means of understanding the wider institutional and sociopolitical issues organizing health care experiences (Smith, 1987).

**Ethical Considerations**

The research procedures were scrutinized by two ethical review panels, one associated with the researcher’s university and one associated with the hospital. These procedures included strategies for assuring confidentiality by removing all possible identifying information from recorded data, field notes, computer files and written reports. To maintain anonymity, patients’ health conditions were substituted with similar but different health conditions, to remove any possibility of identification. Hospital ward names were also changed to prevent the possibility of identifying nurses with their affiliated ward. During the data collection phase of the study, concern centered on assessing informed consent on an ongoing basis, particularly as observational sessions proceeded and as subsequent interviews were sought. In most situations, this involved checking with the patient or the nurse several times as to their interest in proceeding with the study. For example, on one occasion, I
observed that a nurse who had just agreed to participate in an observational session looked extremely busy and stressed as she started her shift. When I suggested that it might not be a good day for the observational session given her heavy workload, she quickly agreed, stating that she preferred not to participate and expressed relief at being able to change her mind. Checking with participants on an ongoing basis – and reminding participants about their right to withdraw – helped to ensure that participants fully understood the components of the study and the voluntary nature of their involvement.

**Ensuring Scientific Quality**

Given that there are no fixed formulas that guarantee valid social knowledge, a critical issue in establishing valid, trustworthy data in qualitative inquiries is the extent to which a high level of self-reflexivity is built into the research design (Dyck, Lynam & Anderson, 1995). On one level, reflexivity is closely related to the research-participant relationship and to the researcher's use of self in data collection (Anderson, 1991a; Lipson, 1991). On another level, reflexivity occurs when researchers place their own social location "in the same critical plane as the subject of research" by examining how assumptions, values, and motivations have influenced the research process, methodological and analytical approaches, and interpretation of findings (Harding, 1987, p. 9). Reflexivity is therefore critical to drawing distinctions between personal feelings, advocacy roles, and sound analytical procedures. Engagement in reflexive analysis is particularly important given the past exploitation of Aboriginal participants in research conducted by non-Aboriginal researchers. For this reason, a section of this chapter (below) is devoted specifically to reflexive analyses of issues arising from positionality and power.

Triangulation is important to establish the trustworthiness of research, and involves
the use of multiple data sources, methods and theoretical perspectives (Lather, 1991). For example, observations contribute to the validity of findings by providing a form of triangulation that can complement or challenge narrative accounts of health care encounters (Reimer Kirkham, 2000; Silverman, 1998).

In studies that draw on feminist methodologies (as this study does), the aim is often to reduce the social distance that typically exists between researchers and participants. Rapport is therefore also an important criterion of scientific quality (Hall & Stevens, 1991). Unless rapport, trust and openness can be established or at least fostered, there can be “no confidence that the research accurately represents what is significant” to participants (p. 22). I view rapport not as something that is present or absent but as a process that can wax and wane as degrees of rapport between researchers and participants evolve over time. As discussed above in relation to the observational and interview methods, varying degrees of rapport were developed with nurse-participants as I engaged with them in routine nursing activities as a nurse with some recognizable clinical credibility. Yet it is plausible that nurses did not behave naturally with their patients (or each other) as I followed them during observational sessions. However, field notes contained numerous references to how hectic the pace of nurses’ work was, and to my sense that nurses did not have time to think about or monitor how they were reacting to patients as they rushed from one patient to another. Nonetheless, it remains impossible to definitively determine the authenticity of nurses’ behaviours during observational sessions; this is a recognizable limitation of this type of social inquiry.

There were, however, possible indicators of rapport that I can report. During observational sessions, a few nurses related to me in an almost business-like manner. In most
sessions, though, it was different. For example, at the end of observational shifts, several nurses commented that they were surprised at how “easy” it was to have me follow them. Some commented that they enjoyed showing me their work. Several candidly revealed their personal and professional viewpoints to me. As I illustrate in subsequent chapters, the ease with which negative comments about Aboriginal peoples were openly shared suggests that nurses were comfortable expressing their views and assumed that I might share their perspectives. During an interview, one nurse noted that she found it helpful to discuss a recent distressing clinical incident. As interviews drew to an end, several nurses described how rare it was to discuss their work with another nurse, and how they appreciated the opportunity. Two First Nations nurses, at the end of their interviews, specifically stated that they thought this research was important. One, for example, remarked that she was “glad to know that someone is looking into these things.” This is not to suggest that all nurses thought the research was relevant: one nurse described how she felt singling out First Nations women was in fact problematic. My general impression, however, was that most nurses related to their patients, and to me, in a genuine manner.

The process of establishing a connection with the First Nations women who were participants began as I spent time visiting informally with patients and visitors at the bedside. Having worked and lived in First Nations communities as a nurse for several years also afforded a degree of comfort moving within First Nations communities as I visited women in their homes after they were discharged. Careful consideration must still be given to my position of power and privilege relative to the women, as I discuss later.

Attending to issues of voice as a criterion of scientific quality is also relevant considering the postcolonial perspectives informing this study (Alcoff, 1991; Reimer
Kirkham, 2000). By purposively sampling First Nations women, and theoretically sampling First Nations nurses, voices which are typically marginalized in relation to mainstream health care discourses have been featured extensively to illustrate the developing analysis.

Finally, Lather's (1991) notion of catalytic validity is consistent with the praxis orientation of this study, and is concerned with how useful the research process and findings are to participants, First Nations communities/organizations, health care administrators, educators and policy makers in raising critical awareness of relevant issues. Evaluation of this criterion is difficult to assess until the research is completed and the process of disseminating the findings begins (Reimer Kirkham, 2000). Ultimately, my hope is that the insights gained from this study will inform strategies for improving aspects of health care provided to First Nations patients. As I have done in previous research, upon completion of the study, I will continue to collaborate with representatives from First Nations communities and organizations, academic educators, and planners from the Regional Health Authority to formulate strategies for using the findings in practice, policy and education.


Linda T. Smith (1999), a Maori scholar, writes: "The ways in which scientific research is implicated in the worst excesses of colonialism remains a powerful remembered history for many of the world’s colonized peoples. It is a history that still offends the deepest sense of our humanity" (p. 1). L.T. Smith’s concern, brought into the Canadian context, draws our attention to the historically determined relationships of dominance and subordination between researchers and Aboriginal participants, the expropriation of knowledge from Aboriginal communities, and the exploitation of communities in past academic research (O’Neil, et al., 1999). These provide powerful reminders of my
responsibility as a Euro-Canadian, middle-class researcher who has chosen to situate myself within the field of Aboriginal health.

A key concern in this study (and research situated within a postcolonial feminist framework) relates to the right to speak and the role of White researchers, as members of the dominant society, in interpreting, writing about, and analyzing the experiences of racialized, marginalized and subaltern women (Alcoff, 1991; Bannerji, 1995; Narayan & Harding, 2000; Spivak, 1988). Spivak’s classic questioning of whether the subaltern can speak draws attention to the complicated relationship between researchers/theorists and subaltern perspectives. The fundamental question posed by postcolonial feminist scholars is whether or not Euro-Canadian researchers – as dominant group members – should or can study, theorize and represent oppressive social relations and experiences (Reimer Kirkham, 2000). As Dyck (1998) explains, “not only is there the problem of ‘us’ representing ‘them’ in the stories we tell, but there is also the problem of what we see and understand being framed by our own location in social relations according, for example, to gender, ‘race’, class, and other positionings” (p. 20-21). In light of these considerations, my initial plan was to train a First Nations research assistant to conduct the in-depth interviews with First Nations women. When, after several weeks, no one was available, I proceeded to collect the data on my own. Almost certainly, a First Nations interviewer would have yielded different data. This too has prompted reflexive, critical evaluations of how my own position within relations of power and privilege has inevitably affected the process of inquiry.

Reflexive consideration of these issues is interspersed throughout the chapters that follow. There are, however, several points I wish to make here. The first is that inquiry from the standpoint perspective is, by necessity, always reflexive (Smith, 1992). As Smith writes,
"it is always about ourselves as inquirers – not just our personal selves, but our selves as participants…. We discover ourselves in exploring the relations in which we participate and that shape how we participate" (p. 94). To overlook my position in relation to the First Nations women I involved in this research would ignore my privileged role as a nurse-academic in the politics of knowledge production (Reimer Kirkham et al., 2002). For example, some readers may perceive me as a Euro-Canadian researcher who, in my position of power, is reproducing paternalistic, neo-colonial relations by speaking for or about First Nations women, rather than speaking with women. These have been concerns since I entered the field of Aboriginal health in 1986, first as a practicing nurse, then as a nurse-academic-researcher. Over the years, I continue to ask myself (as others will ask) how my work may (inadvertently) be contributing to colonial forms of “paternalistic [and maternalistic] caring” (Narayan, 1995, p. 135) and the very practices and processes I wish to disrupt, resulting in “what is essentially a form of academic colonization” (Reimer Kirkham et al., 2002, p. 230). These are complex issues to which there are no easily answers. There are, however, several strategies that I continue to employ to minimize (as much as possible) these contradictions and contraventions.

Throughout this study, and in other research and writing endeavours, I have attempted to avoid positioning myself as the “transformative intellectual” (Lather, 1991, p. 109) speaking on behalf of Aboriginal peoples, even as I seek their perspectives and present their viewpoints to various audiences (Kelm, 1998). Wherever possible, I use verbatim quotations to foreground women’s voices. I draw on perspectives of Aboriginal scholars whose writings encourage me to engage critically with the theory and material I am considering. In Chapter Eight, I consider how my “Whiteness” and professional positioning influenced the
perspectives that women chose to discuss with me (Dyck, 1998). Nevertheless, the
interpretations of women’s perspectives and the findings I present are filtered through my
interpretive voice as the researcher; this must be recognized as a limitation of social inquiry

Writing from my social position influences, but does not necessarily detract, from the
legitimacy of this work. Rather, I concur with Reimer Kirkham and Anderson (2002) who
argue that “rather than pursing the legitimacy of our roles as researchers based on one aspect
of one’s social identity...one’s legitimacy as researcher is based on one’s ability to explicate
the ways in which marginalization and racialization operate” (p. 13). Shaped as it must be by
my own social positioning, my main concern is with unmasking oppressive social relations
(Smith, 1992), not with speaking for Aboriginal peoples.

The second area of reflexive consideration that I address here is how to research and
write about the lives of Aboriginal women without objectifying and homogenizing women as
the different Other (Dyck, 1998). Smith (1999) has been helpful in reminding me that
beginning inquiry from actualities of women’s lives as they experience them does not imply
that women are the objects of research: “The aim is not to explain people’s behaviour but to
be able to explain to them/ourselves the socially organized powers in which their/our lives
are embedded and to which their/our activities contribute” (p. 8). Yet, there remains a risk in
writing (or speaking) about members of a group, in portraying First Nations women in an
essentializing manner as necessarily marginalized, disadvantaged or powerless. This is a
paradox that I continue to confront in my writing of this research. Narayan (2000) speaks to
this paradox, writing, “A postcolonial feminist perspective that strives to be attentive to
differences needs to acknowledge the degree to which the colonial encounter depended on an
‘insistence of Difference’; on sharp, virtually absolute, contrasts between ‘Western culture’ and ‘Other cultures’” (p. 83). As I continue to grapple with these issues, my goal is twofold: (1) to uncover the material and structural specificities that contribute to socially organized relations of domination influencing the everyday lives of many, but certainly not all, Aboriginal women (Mohanty, 1995), and (2) to use generalizations heuristically to highlight historical and colonial patterns of relations, and at the same time, leave room for “attention to differences and particularities of context” (Narayan, 2000, p. 97).

**Concluding Comments**

Sandra Harding’s (1991) challenge for researchers in the postcolonial context is to find ways “to activate their full identities and social situations as whites and to let us see how they are taking responsibility for their identity as whites” (p. 289). By examining my own assumptions, motivations, and positionality – through written field notes, reflective readings, and in discussions with my research supervisor, dissertation committee and colleagues – I have attempted to remain conscious of how these have affected the research process at all stages. These are ongoing challenges. As McConney (1999) has written of her own academic work in Native Studies, “when we challenge racism we give up the relative safety of White privilege....Similarly, we risk making mistakes in our analyses. This can bring on criticism by racialized peoples. Neither of these is adequate reason for avoiding this work” (p. 210). The analyses I present in the following chapters foreground these tensions. This, I suggest, is a step in the transformative process of understanding and (ultimately) undoing the colonial legacies that continue to shape relationships between Aboriginal and non-Aboriginal peoples (Kelm, 1998).
CHAPTER FIVE
NURSES' INTERPRETIVE FRAMEWORKS

Introduction

To assist in the provision of intercultural nursing practice, nurses draw on a variety of theoretical and ideological perspectives garnered through educational programs, accumulated professional experience, and experiences in the social world. Nurses thus bring a range of interpretive lenses as they attempt to make sense of difference (Reimer Kirkham, 2000). In this chapter, I illustrate how these varying frames of reference shape nurses’ understanding of Aboriginal patients and how they influence attitudes. In the next chapter, I examine, more specifically, how these views shape the ways in which nurses relate and interact with First Nations women in the hospital setting.

I begin by examining the range of theoretical and ideological assumptions and discourses that inform nurses’ attitudes, knowledge and beliefs about First Nations patients. For discussion purposes, three broad overlapping categories have been identified: (a) theories of culture, (b) notions of egalitarianism, and (c) popularized images and discourses of Aboriginality. These frames of reference are not mutually exclusive; rather, they are underpinned by common ideological assumptions that form complex and often contradictory perspectives and value orientations toward Aboriginal patients.

The arguments developed in this chapter are not intended to imply that all nurses are similarly influenced or hold similar viewpoints. Rather, nurses incorporate a plurality of discourses and perspectives as they provide care to patients from varying backgrounds. In discussing their work with Aboriginal patients – whether in formal interviews or in informal conversations at the workplace – nurses draw on their knowledge of culture, egalitarianism,
and popularized notions of Aboriginality. These discussions give expression to one predominant theme, however: that of Aboriginal peoples as Other. In this chapter, I explicate the theoretical and ideological assumptions that shape this overriding perception. Later in the chapter, I turn to an analysis of First Nations nurses' understanding of Aboriginal patients to illustrate the extent to which identity, and social and cultural location shape nurses' interpretative lenses.

**Drawing on Theories of Culture in Nursing**

Madeleine Leininger's (1978, 1991, 2002) influential work in transcultural nursing beginning in the 1970s was instrumental in integrating culture into nursing theory, practice and scholarship. Since its inception, the field of transcultural nursing has become a highly influential body of theory addressing cultural sensitivity, cultural competence, and cross-cultural nursing practice. Incorporated into everyday nursing discourses through the proliferation of highly accessible textbooks and articles, cultural sensitivity models typically encourage nurses and health care providers to "become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures" by "seeking and obtaining a sound educational foundation concerning the various world views of different cultures" including "knowledge regarding specific physical, biological, and physiological variations among ethnic groups" (Campinha-Bacote, 1999, p. 204).

In part, the ease and eagerness with which cultural sensitivity models have been adopted in nursing and health care reflects an inclination within the biomedical paradigm to simplify culture into systematized facts that can be elicited as a formula for practice (Lock, 1993). Transcultural nursing textbooks are now widely used to provide nurses with systematized, taxonomic descriptions of cultural characteristics for various groups. These
guide nurses, for example, to tailor their care according to diet preferences, interpersonal etiquette, and culturally-based responses to pain, childbirth, childrearing, etc.

Although a scholarly interest in culture has helped to raise awareness of how culture can shape people's responses to health and illness, we have slipped into treating culture as factual and static, running the risk of essentializing and categorizing people based on differences (Allen, 1996/1999; Anderson, 2000b; Meleis & Im, 1999). These trends have been increasingly critiqued as critical discourses in nursing have taken hold. Scholars working within a critical paradigm have come to see culture through different lenses; unexamined assumptions about culture, as they have been commonly conceptualized in nursing, have been more closely scrutinized. This has led to a reconceptualization of culture as dynamic rather than static and as embedded within a complex nexus of historical, social, economic and political conditions (Anderson & Reimer Kirkham, 1999).

Critical perspectives have drawn attention to unexamined assumptions about culture and values about the Other that commonly underpin theories of culture in nursing. For example, the transcultural nursing model typically equates cultural characteristics with cultural differences, which in turn are evaluated against the mainstream norm (Meleis, 1996). Calls for cultural sensitivity ask us to appreciate and be sensitive to these differences. Allen (1996/1999) points to the problems inherent in such analyses:

Conceptually, such analyses tend, of course, to be stereotypes or overgeneralizations. They also tend to be ahistorical. They are 'essentialist' in that they tend to portray each cultural position as a homogenous set of relatively fixed characteristics (necessary and sufficient conditions for correctly characterizing a particular cultural
configuration as ‘Thai’). This becomes most problematic when it is then applied as a taxonomy to individuals: ‘He is not really Thai.’ (p. 228)

Cultural knowledge and cultural sensitivity without attention to structural, political, or positional constraints may inadvertently perpetuate marginalization by reinforcing essentializing stereotypes and images of the Other (Meleis & Im, 1999). Discussions of culture or descriptions of cultural characteristics are themselves definitional acts creating an Other (Allen, 1999). These cultural constructions of the Other are frequently infused with negative connotations. For example, assuming that “it is in their culture to drink a lot” constructs drinking as an Aboriginal cultural lifestyle. This gives way to expectations applied to all members of the group. Culturalism and Othering become interlocking processes perpetuating constructions of particular cultural groups as inherently problematic or inferior (McConney, 1999; Razack, 1998). It is in this context that the notion of culture has become problematic (Anderson, 1998).

To be clear, the presence of cultural differences or the need for nurses to understand and respond to shared meanings among group members is not in question. The intention is not to suggest that all notions of culture, cultural difference, or cultural sensitivity should be renounced (Culley, 1996). Rather, as Margaret Lock (1993) explains, the danger lies in “jumping into a culturally sensitivity approach...without first examining what we mean by culture and, even more important what our own values are with respect to the culture of the Other” (p. 145). Of particular concern is the propensity in nursing for culturalist discourses to shift attention away from wider historical, political, or material factors that give rise to health and social inequities between and within cultural groups (Culley, 1996).
Although cultural sensitivity can be used as starting place, more complex analyses are needed for nurses to be responsive to such issues as poverty, economic marginalization and racialization. Despite the growing body of critical analyses of culture, culturalist understandings remain predominant in most sectors of nursing (Meleis & Im, 1999). Nursing educational programs, continuing education workshops, in-service training, and institutional mission statements continue to promote a relatively narrow understanding of cultural sensitivity. Most recently, the cultural sensitivity approach has been endorsed in highly influential government reports: Romanow’s (2002) *Commission on the Future of Health Care in Canada*, for example, emphasizes the need for non-Aboriginal health care providers to “learn their [Aboriginal] particular needs and culture” (p. 220). Not surprisingly, nurses, most of who have been exposed to cultural sensitivity models, believe that cross-cultural training will help to overcome the biases or judgemental tendencies observed among some of their colleagues:

RN: They are getting better. It is getting better. Yah it is. The more we are learning about different cultures and stuff like that and having the cross-cultural classes in the nursing schools and stuff help. Just experience helps, working with different cultures. That helps a lot too. And a nurse, one of the things they teach you in nursing is nonjudgmental. If you are working with a diabetic, you can’t judge them because they have a piece of pie, or, if you are working with ah, somebody who has liver failure and are drinkers. You are supposed to approach them as nonjudgmental. You can’t help somebody if you are busy judging them for what they are doing. It is the same with the Native people. You can’t help them, you can’t expect to get their cooperation or help them, if you are judgmental in the way you approach them and
again I think it is attitude. It is not necessarily what you say. It is attitude. It is approach and a lot of that is non-verbal, non-spoken and that is true of anybody you look after.

Professional scripts about the importance of remaining nonjudgmental reflect an idealized notion of cultural sensitivity in which the ideals of respect, tolerance and caring can counteract personal biases. This reflects the dominant, rationalist perception in health care that more cross-cultural knowledge will dispel ignorance, surmount prejudice and improve health care (Culley, 1997). Nurses who see themselves as lacking cultural knowledge therefore describe their work with First Nations patients as “more challenging” because of their inability to interpret assumed cultural differences, practices or beliefs.

Despite their sense of working from a deficit position, nurses were unwavering in their commitment to treat all patients equally regardless of culture:

RN: I treat nobody of any culture any different. Like, I treat people equally, all the same...Everybody has cultural beliefs and practices that you have to take into consideration with their care. So that’s always a challenge. And I think more of a challenge for me because I didn’t have, I didn’t train here. Whereas here they focus quite a bit on, like, East Indian culture and Native culture. But when I did my nursing we didn’t focus on those things.

Recognizing the importance of eliciting cultural information, nurses attempt to use assessment tools provided on standard hospital admission forms. Items on these forms represent efforts to tune hospital staff into patients’ cultural orientation. The usefulness of

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47 The notion of scripts refers to societal, cultural and professional expectations about particular behaviours or knowledge that should be expressed in specific situations (Abelson, 1981). In the context of this study, scripts reflect nurses’ or patients’ assumptions about what may be acceptable and expected in relation to a given topic of discussion.
these items, however, is constrained by the nature of the questions and the responses they illicit:

RN: Whenever any patient comes into our ward, we do a complete history and included in that is diet along with all their other medical history and then we also talk to them about cultural and religious practices and how they feel the hospitalization will impact on that. We always ask that question in our history.

A: \(^{48}\) Do people tend to answer that kind of question or is that sort of a, a big question? I'm just curious to know.

RN: Yah people usually do. Most people say there are no interferences. Because I have asked lots of Native people are there any cultural or religious beliefs that we need to consider with their care and a lot of them say no. A lot of people will just tell me their religion, like I'm Roman Catholic or whichever, Protestant, whatever they happen to be. They will just tell you their religion. I don’t think I have had; a lot of people say, well “I am vegetarian” or you know, things like that but you don’t get too many people that say the hospital is going to interfere with their cultural beliefs at all. That is usually not a problem.

Without any other assessment tools to draw on, these items convey the sense that information about culture ought to be easily elicited. The fact that most patients do not come forth with any substantive responses reinforces notions of cultural needs as extraneous or easy to suspend so as not to interfere with hospital routines (Lock, 1993).

Although patients' may not have come forward with cultural issues requiring consideration, their practices may indicate otherwise. For example, guided by a cultural sensitivity model, nurses recognize the benefits of culturally-based alternative healing

\(^{48}\) In the data excerpts, “A” refers to me as the researcher.
modalities and attempt to remain nonjudgmental. A nurse explains her initial impressions of a patient’s use of a traditional remedy:

RN: And then another thing I ran into when I first got hired and I had a patient who was Native and the Natives have different things like they, you had a wound, and they had I think it was bear fat or something. They wanted to do their own little ritual for healing with this stuff, to put this bear fat on his body and stuff. So you, I mean you just have to let them go ahead and respect their culture and what they do as long as it is not harming the patient at all. So I just basically, that was my first interactions then with like things like that so you just sort of stand back and let them do their thing.

Reflecting a common transcultural nursing perspective, this nurse shows respects for traditional remedies by “letting them do their thing.” At the same time, one can sense how the use of bear grease is representative of difference. This formative observation is stored as evidence of how different First Nations patients can be. Cultural sensitivity, which rightly directs nurses to permit patients to use culturally-based healing approaches, does not, however, provide a lens for analyzing the inherent power differentials at play; namely, that it is the health professional who conveys tolerance and grants or withholds permission.

One feature of the wider social discourse of democratic racism (introduced in previous chapters) is the framing of culture in the context of tolerance, sensitivity, and respect for diversity (Henry et al., 2000). Cultural sensitivity as it has been applied in nursing is founded on principles of tolerance. Tolerance, however, is not a politically neutral term. Rather, as McConaghy (2000) argues, “The tolerance and intolerance binary masks the more significant underlying binary of the tolerating majority and the tolerated minority, a power-
laden division which lies at the heart of Australian multiculturalism,” (p. 41) and I would add, Canadian democratic values. In the Canadian context, liberal notions of tolerance and respect for First Nations culture often mask the racialized assumptions embedded in these discourses (Ponting, 2001).

At the heart of liberal tolerance is a fundamental ambivalence toward the minority Other (Henry et al., 2000). Not unexpectedly, members of the dominant society can slide ambivalently between fascination and disdain for others’ cultural differences (Furniss, 1999). For example, exaltations of Aboriginal peoples as “more ‘spiritual’, more ‘interesting’, or more ‘cultural’” than the Euro-Canadian majority can be as objectifying as negative stereotypes (McConaghy, 2000, p. 42). With this in mind, excerpts can be read in different ways. On the one hand, some nurses seemed to speak with reverence about First Nations spirituality; on the other hand, these descriptions could be interpreted as romanticizing or exoticizing First Nations culture:

RN: I find I cannot think of a Native person I have ever looked after that was not a gentle person. I really can’t. They are very gentle people....and the elderly women are, I don’t know, I just want to take them in my arms. They are delightful....I think my basic premise especially with elderly Native people is that they have a wisdom and a spirituality that many of us, I think, never achieve. They just know things. They just know. And I am very respectful of that and I am very respectful of how that is viewed by the other members of their family.

From a more skeptical interpretive perspective, the nurse’s cultural gaze could be interpreted as a colonial gaze: fascination with Aboriginal elders and spirituality reinforces

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49 I use “gaze” as Bannerji (1993) and Dyck (1998) do, and as originally conceived by Michel Foucault, as a lens of and for power.
re/presentations of Aboriginal peoples as exotic Others. From a less dubious position, the nurse is merely expressing genuine admiration for the elders she has encountered in her practice. Perhaps the soundest interpretive stance is one that considers both possibilities.

Cultural discourses also permit nurses – as members of the dominant society – to discuss social problems assumed to be characteristic of First Nations patients in (supposedly) neutral terms. Often embedded in these discourses, however, are value and moral judgments. Gendered assumptions about First Nations women as cultural Others, for example, illustrate how value judgments seep into discussions about First Nations culture. When discussing a recent patient, this Euro-Canadian nurse offered her interpretation of one woman’s situation:

RN: She just looked so young and when I found out she was 32, I thought whoa, because she acted very young. I don’t know if that is because she didn’t take any care of any of her own responsibilities or what it was. Because she didn’t look after her own child. Now, I know that is a cultural thing [emphasis added].

As previously noted, views of Aboriginal women as neglectful mothers are not uncommon among health care providers and social service workers (Browne & Fiske, 2001; Rutman et al., 2000; Sherley-Spiers, 1989; Tait, 2000a, 2000b). Rooted in historical efforts by government officials, Indian agents and missionaries to disparage the morality and abilities of Aboriginal women, these images remain embedded in popular culture (Eisenberg, 1998; Green, 1995; Gunn Allen, 1995; Stevenson, 1999). What is important about this statement is how the term cultural is used to couch this nurse’s negative views in ostensibly acceptable terms. Implicit in this statement is a view of Aboriginal women, in general, as irresponsible, negligent mothers; by labeling these qualities as cultural, the way is opened for an expression of prejudiced views (Henry et al., 2000).
Social problems, conflated as cultural characteristics, are further markers of Aboriginal peoples as cultural Others. A Euro-Canadian nurse, wanting to be sensitive about the multitude of social problems that many Aboriginal peoples face, struggles to find the appropriate phrasing:

RN: Yah, so you get, because, there, I find with Native people is, just the way their culture is, I think you get a lot more you know social things that you need to deal with you know. A lot of, not necessarily problems but you know, there's, there are...what am I thinking of, they are very complex socially and you need to look at a lot of things.

Our continued discussion was recorded in field notes:

The nurse also went on to describe some features of “Native culture”. She commented that “it is in Native culture to have a lot of violence, a lot of stabbing, a lot of alcohol abuse and a lot more violence than what you see in other cultures.” She also added that “this doesn’t mean that all Native people are drinking or in violent situations” but that there seems to be a lot more of those issues in Native culture. [Field note entry].

Without critical consideration of the underlying dynamics of social problems, nurses can equate the culture of poverty, violence and substance abuse with the culture of First Nations peoples. As culture becomes conflated with ‘race’, First Nations people are discussed in ways that objectify them as Other. Ramsden (1993) observed a similar pattern of understanding among New Zealand nurses who tended to mistake the culture of poverty for Maori culture. Whereas in New Zealand, all nurses are now required to learn about “the poverty cycle and the various histories and sociopolitical conditions which establish and maintain it” (p. 8), no such formal strategies exist in the Canadian context. In the absence of
competing frames of reference, nurses draw on established theories of culture – underpinned as they are by culturalist discourses – to interpret social problems that seem prevalent in their practice with First Nations patients. Culture becomes reified as the primary explanatory variable while social constraints on allegedly culturally-determined lifestyles are downplayed or ignored (Culley, 1997). From the culturalist viewpoint, complex social problems are reduced to over-generalized stereotypes: statements made by nurses suggesting that “quite often this culture, they do drink a lot” are viewed as both plausible and acceptable. The actual everyday experiences of material and social hardship that organize people’s experiences of substance abuse, violence and poverty therefore remain unexamined.

**Drawing on Discourses of Egalitarianism**

Just as theories of culture – as commonly applied in nursing – shape nurses’ understanding of difference, so do the values embedded in discourses of egalitarianism. As a principle inherent to professional nursing, discourses of equal treatment reflect prevailing views of Canadian society and its institutions – including the health care system – as essentially egalitarian, just and fair (Browne, 2001). These beliefs rationalize nurses’ faith in the clinic as a relatively neutral microcosm of society immune to pervasive social relations of power and privilege.

Nurses in this study were unwavering in their commitment to treat all patients equally. The theme “equal treatment for all regardless of background” represents a shared ideological discourse and professional script. Consistent with a “colour-blind” stance as an appealing and powerful liberal discourse, egalitarianism assumes an equal playing field: all people have essentially equal life opportunities and should be treated the same regardless of their social, cultural or gendered locations (Henry et al., 2000).
Egalitarianism as a professional ideology is reinforced through the Canadian Nurses Association (2002) *Code of Ethics*. The nursing value of justice requires nurses to “uphold principles of equity and fairness to assist persons in receiving a share of health services and resources proportionate to their needs and promoting social justice” (p. 15). To fulfill this value “Nurses must not discriminate in the provision of nursing care based on a person’s race, ethnicity, culture, spiritual beliefs, social or marital status, sex, sexual orientation, age, health status, lifestyle, mental or physical disability and/or ability to pay” (p. 15). Hence, as an integral part of their professional identity, nurses believe that they see all people – and treat all people – on equal terms (Barbee, 1993; Reimer Kirkham, 2000). Underscored by a concern to maintain impartiality, the emphasis on fairness and equity is imperative to nurses’ self-image and role identity.

In some instances, nurses struggled to reconcile notions of egalitarianism with culturally responsive care:

RN: I mean, I change my nursing accordingly, but you don’t go out of your way to not do something for a person because they are of a different race or anything. Like I mean you do everything the same. You just have to consider their culture and if they wouldn’t do this sort of thing. You just have to, it is just the basic, how you treat them is, I treat them equally. You know how you talk to them, things like that. How you interact with them and their family. In that way I treat them equally. … Like I go about my approach to a person whether they are White, Black, Native, East Indian, you know I approach them in the same manner and get to know them the same as I would anyone else.
One nurse expressed concern about the ease with which some of her colleagues labeled or categorized First Nations patients as “drinkers,” for example. She saw these practices as eroding the principles of equal treatment. With hesitancy, she wondered if this represented a form of prejudice:

RN: No, I don’t think I have seen any particular instance of discrimination. Many people a lot of times get categorized, sometimes. That would probably be the only thing... And I find quite frequently people may jump to the conclusion that if someone [a patient] is confused, they drink, and they categorize Native people as drinking quite frequently. I mean there are lots of people who drink. I mean that is like, myself, you know, there is a lot of White people that drink – I particularly don’t drink – so I think maybe in that instance they might get a little categorized there. I mean 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.

Suspicious about eroding principles of egalitarianism by tuning into issues of ‘race’, nurses were clear about the need to maintain a colour-blind perspective. As an idealized notion, colour-blindness makes intuitive sense to nurses. Without opportunities to critically engage with these issues, however, nurses’ attention is deflected away from the historical and social implications of racial categories that organize people’s everyday lives. As Henry et al. (2000) pointedly notes, “colour evasion leads to power evasion” (p. 27). Having few opportunities to reflect on the paradox of colour-blindness, the full ramifications of this perspective remains invisible (Drevdahl, 1999).

While some nurses framed issues of discrimination as a “thing of the past,” believing that “they are all smarter than that now, that is no longer acceptable,” others believed that
egalitarianism could override these tensions arising in the wider social world. This kind of faith made it difficult for the Euro-Canadian nurses in this study to conceive of health care inequities that might exist within their institution. For most, the hospital was impenetrable to discriminatory processes that occurred elsewhere:

    RN: I mean I would like to think that we don’t see race or colour but of course, I think that would be an over simplification because of course we do. Of course we do.... [But] I have never, I cannot think of a time in all the years that I have heard a colleague berate somebody because of their nationality. I think that we would all be very, very intolerant of that. I honestly cannot, I have not encountered that where I work.

Not intending to trivialize the issues, this nurse uses phrasing (as many Canadians would) that avoids the discomfort of ‘race’: speaking in terms of nationality, ethnicity or culture is (seemingly) less contentious.

In some cases, as interviews proceeded, nurses gave more thought to issues of social inequities and, in the end, questioned their own level of awareness. In these instances, the interviews served as a catalyst for critical reflection. One nurse pondered on information disclosed to her about a physician who was observed to differentially treat patients from a “different cultural background”:

    RN: Apparently one fellow nurse was telling me we had a patient with a different cultural background and you know this patient wasn’t being seen by the doctor, etc. And at that point they mentioned to me well don’t you notice how he treats this particular culture as opposed to other cultures? And I haven’t noticed it. Then, I am not looking for stuff like that. ....But apparently you know, from this nurse’s point of
view, she does feel that this doctor is discriminating against certain people. So I am sure it is possible that it is out there. I am sure that it is possible that some nurses, you know. The people I work with, the people I have come in contact with, I don’t notice it but then I am not particularly looking for it. I guess maybe I am a little naive that way because I don’t act that way. I expect no one else should.

Naive faith in the principles of egalitarianism persists despite nurses’ daily contact with embodied representations of social inequities. One of the reasons that people resist anti-racism discourses is this ability to overlook “the relation between cultural and racial differences and the power dynamics constructed around ideas about those differences” (Henry et al., 2000, p. 24). Instead, egalitarian discourses are evoked – albeit unwittingly – to cover up or avoid the unpleasantness of power differentials and inequity.

When infringements on fairness and equity in health care were discussed, they were most often located outside the neutral territory of the hospital. For example, recognizing that equal access to health care may be constrained for some patients, this Euro-Canadian nurse is adamant that once patients “get through the door,” the principle of equity kicks in:

RN: I mean once somebody gets through the door, you may have trouble getting through the door but it doesn’t matter if you’re, you know like you said the different things that come into it now. It doesn’t matter if you are down here on the social economic scale, or if you are up here on the social economic scale. You are going to get exactly the same [treatment] and I truly believe this. You are going to get the same because the doctors are going to order the same antibiotics, the same medications to treat what is wrong. And I mean, I really feel that. I do not feel that there is any difference in how people are treated once they get through the doors of
the hospital.... I guess when I say equal treatment I am talking about from the top.

Like the same medications will be ordered, the same tests will be ordered.

Meeting the physical needs of patients regardless of socioeconomic background is presented as evidence of equity in health care. This line of reasoning overlooks the ways in which interpersonally mediated power relations organized around racial, gender or class differences may shape patients' experiences within the health care system. The ideals of egalitarianism, it seems, constrain this nurse from considering in more depth the continuum of access inequities she initially identified as problematic.

Critical reflection on one's own positionality and responses to difference is one of the first steps in the development of critical consciousness (Reimer Kirkham, 2000). Although opportunities for critical engagement were constrained by the structure of nurses' work and by the lack of any informal or formal venues for discussion, nurses reflected on their attitudes and potential biases during the research interviews. One nurse described how difficult it was for health professionals to suspend their biases and preconceptions about First Nations people visible "out there" in the social world. These biases compete with the ideals of egalitarianism:

RN: Individuals have individual perceptions, individual biases, and you can't stop being who you are and a case of bias comes through or the prejudice comes through depending on how you were brought up. What you experienced in your life, depending on how strong it is, and you are dealing with that person. Like I say, I myself have always had a prejudice against addiction but through more education on my part, I have learned that maybe I am not right about that....I don't think you can completely get rid of it. Because we are people.... And we have varied experiences.
We live out in the communities when we are not working and you bring yourself to work. You do. And the best thing you can do is just try not to let it show in your work but I know that it does. I have seen it. We have all seen it.

These insights concerning the tensions that can arise as health professionals reconcile their own biases against the powerful ideology of egalitarianism are important to pursue as part of a transformative agenda in health care. Nurses, however, are caught in a dilemma: while some are prepared to discuss these issues, to do so might challenge their image as good nurses.

Without opportunities to reflect on racism or other prejudices as socially and structurally organized, biases are understood as arising from the poor attitudes of individuals. These individuals are framed as exceptions:

RN: But you get your good and your bad. Most of them are good. We have got a good group up there but you get a couple who are very redneckish and don’t want to know anymore. They just want to know what they need to know to do the basics.

Yah, I like to look a little further...It is not a huge, I don’t see a lot of it, I don’t. Most of them [nurses] are professional enough if they do have those feelings, they go in and do their jobs and then they leave. I have seen nothing really overt. I have heard a few comments at the [nurses’] station. I don’t put up with it, so people don’t tend to say that around me. But I have, I have never seen anything. But I know the feelings are there.

The presumption is that professionalism can override biased attitudes. This nurse’s analysis is not atypical. Our disciplinary discourses support and reinforce these (unrealistic) notions; nursing theories and discourses tend to be grounded in liberalist notions of tolerance, respect
for diversity and equity (Browne, 2001). These ideological premises continue to divert
nurses' attention away from the complexities of working within a racialized, classed and
gendered society. Professional discourses also constrain opportunities for the kinds of critical
analyses and conversations that might begin to shift nurses' thinking about issues of 'race',
racialization, culture, etc. Instead, the sense is that conflicting attitudes toward First Nations
or other groups can be concealed. Responsibility for overcoming biases and upholding the
(impracticable) ideals of egalitarianism, then, lies with individual nurses who must do their
best "not to let it show":

RN: And I mean you have to do it individually. You have to make up your mind that
you are going to try as much as you can to treat everybody equal and, I mean
sometimes it becomes hard, you know. You may generalize or I mean people
generalize all the time. People might say, I mean I hate it when I see people say,
"well, all Natives are drunks." Well, no, they are not. You know I mean it is like all
White people are drunks. Like a lot of White people go out drink, get drunk, they do
stupid things. But that doesn't mean we all do it as a culture and so, I mean I
personally am very leery about categorizing people that way in groups. That is like
well you take our current situation in life right now, people with the terrorism. I think
people generalize a particular religion. They are all terrorists. Well no they are not,
right? So I mean you have to watch yourself in life that you don't do that. I was
raised not to do that so I mean it is just a very individual thing and with nursing you
have to be careful.
Professionalism has its limits, however: nurses sometimes cannot see how their own biases conflict – and in some cases override – the idealism of egalitarianism. This Euro-Canadian nurse locates herself within the stereotyping comments she overhears at work:

RN: This is an offhand remark [made by another nurse] about, somebody will come in, I am trying to think of what that last one, the abdominal pain, history of alcoholism, drug problems, seizures yadda, yadda yadda and somebody would say something “oh it’s probably another Native,” that sort of thing. Which – we get a lot of them – is a little hard to say that they are wrong. It is an inappropriate line, but it is real. I don’t know what we are going to do about it but it is very real. And a lot, I hate to say it but a great percentage of the Natives that we get in there have a problem. Usually it is drinking. I mean it is poison to them, just poison. Physically. Drugs not so much but the alcohol is the big one. Mind you we get a whole pile of White ones in there too.

Although the negative statement toward First Nations people is identified as inappropriate, this nurse has difficulty condemning it as incorrect given the ample evidence in her immediate experience. Here, beliefs about First Nations as Other are expressed without mobilizing the (more politically correct) metaphors of culturalism. Although she contravenes her early claims about viewing all people equally, she is unaware of her own prejudiced attitudes. This is true for most people, who remain largely unaware of their prejudices or the ideologies informing their viewpoints (Henry et al., 2000).

Rather than analyzing prejudiced attitudes as individual opinions, they are more adequately conceptualized as strongly connected to the social relations in which they are formed. Individual prejudices therefore need “to be placed in a broader sociological context
because attitudinal manifestations of racial inequality are related to social, political and
economic stratifications that form social structures and arrangements” (Henry et al., 2000, p.
53). It is to these socially organized discourses concerning First Nations people in Canada
that I turn my attention to next, and to their influence on nurses’ knowledge, attitudes and
practices.

**Drawing on Dominant Ideological Perspectives**

In this section, I explore the ways in which nurses’ understanding of First Nations
people are shaped by images and messages generated within the wider society. My aim is to
socially locate the sources of nurses’ knowledge and attitudes toward First Nations people.
To accomplish this goal, I draw on the concept of dominant culture as articulated by
Raymond Williams (1980) and applied analytically by Furniss (1999):

> In any society, in any particular period, there is a central system of practices,
> meanings and values, which we can properly call dominant and effective... It is a set
> of meanings and values which as they are experienced as practices appear as
> reciprocally confirming. It thus constitutes a sense of reality for most people in the
> society. (R. Williams, p. 38)

Furniss explains further: “This dominant culture infuses many domains of everyday life from
family life, school, the media... A dominant culture, in essence, is experienced as a set of
common-sense, taken-for-granted truths about the nature of reality and the social world” (p.
14).

This is not to suggest that all people ascribe to the values or practices of the dominant
culture in the same way. Individuals and groups are variously positioned within fields of
social and political power, giving rise to differing viewpoints and discourses that both challenge and reinforce the legitimacy of a dominant culture:

A dominant culture, then, is a selective worldview that is continually being challenged by alternative systems of meaning and belief. Its dominance lies in both its ubiquity and its flexibility: its ability to be continually modified in order to deflect or incorporate challenges to its legitimacy. (Furniss, p. 15)

Anthropologists Furniss (1999) and Dunk (1991) have applied the notion of dominant culture to illustrate how a prevailing cultural discourse in Canada – that of Aboriginal peoples as the inferior Other – continues to shape public consciousness and attitudes toward First Nations people. The aim of the analysis in this section is to illustrate how ideas central to this discourse shape nurses’ knowledge and attitudes, and find expression in discussions of First Nations patients.

**Constructing the Other**

Constructions of First Nations people as Other compete with professional discourses of egalitarianism. The contradictions inherent within these discourses are not unusual. As strands of liberal ideological discourse, contradictions and paradoxes are expected. Henry et al. (2000) identifies liberalism as both egalitarian and non-egalitarian: “It simultaneously supports the unity of humankind and the hierarchy of cultures. It is both tolerant and intolerant” (p. 30). Remaining aware of how dominant views are given expression through liberal discourses helps to explain how nurses can view everyone as equal and at the same time, view Aboriginal peoples as negative stereotypes.

The image of the “drunk Indian” has been invoked in several preceding excerpts. Fuelled by colonial myths about genetic vulnerability to the effects of alcohol, this is one of
the most enduring colonizing images pervading public consciousness\(^{50}\) (Furniss, 1999, p. 107). A Euro-Canadian nurse echoes these beliefs as she discusses the challenges of working with some First Nations patients:

RN: It is kind of sad, especially with the ones that can’t tolerate it and First Nations can’t. I think they have proven beyond a doubt that it’s poisonous to the system and has been for a very long time.

As she continues, discourses of respect and egalitarianism are interspersed with constructions of us/them binaries. These binaries reproduce and reinforce stereotypes — stereotypes assumed to be so taken for granted as to be invisible.

RN: Well you have to go in with an empathetic attitude... Um, respect, just show them respect when you go in there. Have an empathetic attitude but don’t let them get away with, a lot of what they try and get away with. I find a lot of drugs is a real big problem with First Nations. They like them.

She goes on:

RN: No, I don’t approach them any differently, until I find out... No, I look at them as individuals. I would look at them no matter pink, green or yellow and find out what their different needs were but I don’t, the only thing I do with First Nations is if I know I have got somebody in there who is very ill that I am going to have a problem with and when I told you about the visitors, with them getting enough rest, that sort of thing.... You know you look at what your job entails and what you need to do with

\(^{50}\) The image of the drunk Indian cannot be accounted for as mere personal opinion (Furniss, 1997/1998). Rather, these images have originated within the domains of public history that continue to shape Canadian popular consciousness. Furniss analyzed current high school texts in BC and found colonial myths of Aboriginal peoples as “inherently weak and incapable of controlling their compulsive thirst for alcohol” to be prevalent (p. 18). These continue to be used as primary sources of information for BC students.
your job. I don’t see...they don’t really have different needs. We’ve got just as many alcohol problems with Whites as with First Nations in the hospital.

What is critical about this statement is not the individual attitude or beliefs expressed. Although one could argue that individual nurses ought to be more accurately informed, the issue of greatest concern is the extent to which this nurse’s thinking is organized by racialized assumptions and values. Essed (1991) explains the importance of analyzing racializing practices as socially mediated. She emphasizes, “racial or ethnic beliefs or opinions expressed by individual dominant group members are not relevant as personal opinions but as reflections of socially shared representations of racial and ethnic groups” (p. 45). By focusing on racist expressions as a social problem, we can more easily recognize how dominant “ideologies are saturated in the cognitions of agents” (Essed, p. 46).

Images and discourses of Aboriginal peoples as dependent wards of the state, as undeserving, and irresponsible are variously, but continuously, re/presented in the media, films, history books and public conversations (Acoose, 1995; Furniss, 1997/1998, 1999). In the absence of counter discourses, competing images, or positive personal encounters, nurses draw on these discourses to form an understanding of Aboriginal peoples. An editorial in a major city newspaper provides one example of discourses that are taken for granted as acceptable:

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. They tend to develop expectations that cannot possibly be met. People around them come to resent them, a situation that fosters an unhealthy society... 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 county. (Yaffe, 2002, p. A14)

This excerpt is not an isolated diatribe. Furniss (1999), Dunk (1991) and Ponting (1997, 2001) have documented the extent to which similar assumptions of Aboriginal peoples as free-loading subjects who unfairly benefit due to ‘race’ are expressed matter-of-factly as dominant public viewpoints. Professional education and socialization do not prepare nurses to think critically about these political and social issues. Nurses who believe that Aboriginal peoples “get everything for free” are (uncritically) reflecting perspectives organized through “socialization and the constant actualization, through the media and other channels of communication, of images, opinions, and version of reality legitimizing the status quo” (Essed, 2002, p. 188). The views expressed by a Euro-Canadian nurse (and reiterated by her colleagues) mirrors those expressed in our nation’s newspaper:

RN: Yah, they pretty much expect you to look after them. They expect to just be able to do whatever they want to. They have a different [small laugh] philosophy, Native people do. They want you to spoon feed them. The government spoon feeds them, and it filters right on down. They are very much into the system. They know how to work the system. They know how to milk it for everything they can get out of it and that is just, something because that is what they do, that’s how they live, and I think we precipitate that as much...as they do.... Because I mean it starts when they are little. The government gives them this. They don’t have to pay taxes. They don’t have to work. The government looks after them. The government gives them money. The government gives them land, pays for their school. What do they have to do?
And that filters right on through when they come in here, they expect you to give because they are used to having it handed to them.

In a clinical context, dependency on the system becomes linked to dependency on pain medications or illicit drugs. Since nurses have frequent encounters with hospitalized patients who may be ill as the result of drug or drug abuse, myths about weakness for alcohol or substance abuse transform into proof. Underlying these constructions of Aboriginal dependency is the expectation that people should be able to overcome social problems, become self-sufficient and assume personal responsibility for their lifestyles. To do otherwise is to run counter to dominant social values:

RN: I just don’t think that throwing large sums of money without any direction or any guidance or any programs to help people that have been kind of... sidelined for a long time and really don’t know how to go about getting educated or getting out of, you know, alcohol induced situations. I just am not convinced that just the money is the answer.... We simply look after them and as a result they don’t have a bottom line maybe the way you or I would have and so maybe the need then to go forward and make it all right for yourself isn’t as acute as it is for us. That might be incorrect but it is something I think I see in looking after Native people.

Liberal notions of individual responsibility, self-reliance, and equality of opportunity are “deeply embedded in the ideological frameworks that underpin the construction of the Canadian nation.... The notion that equal opportunity is available to all, and that individual effort is responsible for success (Li), is as much a part of the ideology of health care as it is a part of the ideology of other institutions” (Anderson & Reimer Kirkham, 1998, p. 243). As discourses underpinning the epistemological basis of much of our disciplinary knowledge,
nurses are not typically taught to question or critique these dominant perspectives (Browne, 2001).

Nurses’ general lack of appreciation for the historical and current contexts of dependency signifies that they bring an incomplete analysis of these issues to their practice. Razack (1998) highlights the problems that arise:

Without history and social context, each encounter between unequal groups becomes a fresh one, where the participants start from zero, as one human being to another, each innocent of the subordination of others. Problems of communication are mere technical glitches in this view, misunderstandings that arise because the parties are culturally, racially, physically, mentally, or sexually different. (p. 8)

Although Euro-Canadian nurses were aware of residential schools as a particular issue, only vague references were made to the overall historicity of Aboriginal health. When considering why many First Nations patients were quieter than other patients, for example, this nurse gives brief recognition to an underlying notion of history at play:

RN: The younger ones are a little, like the younger First Nations women are a little more open and that, but they don’t have a lot of the history that the… you know, they are more Canadianized than say the generations older than them are, but I still find they are, you know, they are quiet. You know they don’t talk a lot. The women especially.

Quietness is interpreted as a function of assimilation – or more specifically, lack of assimilation. The possibility of quietness as a function of long-standing relations of authoritarianism and paternalism is less obvious. Viewing patients from an ahistorical
vantage point therefore leads nurses to an entirely different analysis than might otherwise be achieved if historical contexts were considered.

Historical knowledge (or the lack thereof) shapes our awareness of the current sociopolitical landscape. As noted in Chapter Two, data collection took place during a time of heightened political tensions as the BC Liberal government launched the treaty referendum. In the surrounding region, discussions about land claims and Aboriginal entitlement were common-place both outside and within the hospital. Among nurses, these everyday conversations were expressed behind-the-scenes, at charting desks, the nurses’ station, medication counters, and in lunch rooms and corridors – in spaces away from patients. These informal comments, shared among insiders, provide a window into nurses’ common-sense assumptions. A First Nations nurse party to behind-the-scenes comments described the distress she experienced as she heard her colleagues discuss a newly admitted indigent Aboriginal patient:

LPN: I remember the one guy. He came in with a head injury from a single vehicle accident. Oh it, just one of those instances where you just want to cry....We got him up into the bed and we just cut his underwear and his socks off. I swear he hadn’t changed them in weeks, weeks. If not months. He was just covered in dirt from head to toe so we did what we could, and you know and made him comfortable. I felt that everybody was working together. There was about five of us, a big guy to get him into the bed and stuff, and at that point I didn’t feel anybody was being, withholding care for any reason. Everybody was doing what was required of them. But then as we were leaving somebody made a comment saying “there is your argument for land claims.” And, you know the conversation kind of turned. I don’t know maybe there
was something about land claims in the newspapers or something at the time, because the conversation at the nurses’ station turned towards that specifically. You know and this is where all the money is going, and just a general attitude about that. You know, I wanted to cry for this man and this is what I said. You know can you imagine? 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 and they mean nothing. You know this man has nothing to do with land claims, nothing. He is not going to see a dime. You know? That is just the one instance that really sticks out in my head. I will never forget that but God I felt bad for that man. Just awful. Where everybody else was quite, I don’t know if antagonistic is the right word. Like I said, they provided the care, absolutely. But it was afterwards that you could tell there was a lot of bad feelings you know about the treaties and the land claims and the situation that was going on at the time.

From the viewpoint of her Euro-Canadian colleagues, this man stood as a marker of Aboriginal incompetence and unworthiness. Embodying a prototypical negative stereotype is evidence of how incapable Aboriginal peoples are to govern their own affairs. Although disparaging remarks might also be leveled toward other non-Aboriginal indigent patients, they are unlikely to be put forward as racialized and politicized markers of their Nation.

The dominant discourses reflected in these comments do not arise in a vacuum: they are part and parcel of ongoing public debates about Aboriginal-state relations (Furniss, 1999). The excerpt below sums up the frustrations shared by many:

RN: Well it came up with the problem with the fishing. Yah if they want to go back to their cultural roots and fish and take whatever they want whenever they want then
that is fine, but leave the jet boats and everything here. They can go out with a bow
and fishing and whatever, which is true...When do we stop paying for our ancestors
mistakes? I would like an answer to that one personally. I would like to see people
integrated into one society. Keeping their own identity but everybody has to work for
the same goal. Don’t get me started on that one. I haven’t worked out all the glitches
yet.

The ceiling on liberal tolerance, egalitarianism and respect for diversity is drawn here. As the
treaty referendum illustrated, the dominant culture retains a powerful voice on issues of
Aboriginal rights, special status, or self-government. Although some nurses could identify
these attitudes expressed as “redneckish,” most seemed unable to see their own role in
contributing to these discourses. Henry et al. explains how racist attitudes are difficult to
recognize in one’s self because they are derivative in nature, and because “they grow out of
and are sustained by the structure of social relations of which they are largely a psychological
reflection” (2000 et al., p. 53 citing Parekh, 1987). To gain a greater awareness of racialized
relations and discourses – and one’ own positioning within these relations – would require
the opportunity and space for critical knowledge development. Generally, these areas of
inquiry remain unexplored territory for most hospital nurses.

**Alternative Views**

Not all Euro-Canadian nurses were similarly influenced by the dominant viewpoints
illustrated above. The extent to which competing ideologies influence individual attitudes is
variable: individuals internalize some assumptions and not others (Essed, 1991). Living
within or adjacent to rural First Nations communities over a long period of time, for example,
provided some nurses with lived experiences that countered dominant images and myths
about Aboriginal peoples. One Euro-Canadian nurse spoke about her experiences living and working within a First Nations community, and how this influenced her own growing awareness of the wider issues influencing women’s lives.

RN: So that again, brought me back to dealing with women and that was actually a very good experience. The issues that came out of that experience were, I hadn’t recognized a lot of those issues...Women, I found, once you gained their confidence would share lots with you. And most of them because they are very family and nurturing orientated would come to you and were always, the majority were so concerned about their kids... And then 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 are going to be educated and they were better than being put down all the time. Those issues were quite apparent.

Another nurse in the process of completing a BSN degree described how university studies – particularly an ethics course – shifted her analytical lens by helping her to think critically about precepts of egalitarianism and inherent worthiness:

RN: Well I guess we treat but we don’t treat people the same. You know. Meaning different people need different things. So if you could interpret it treating people equally meaning that you do the same thing for everyone, that is not true. When we say we treat people equally, what we hope to achieve is that everyone is of equal value. We don’t treat everyone the same because we all have our different needs and different backgrounds..... They are still equal but their needs are different.

Of the twelve Euro-Canadian nurses interviewed in this study, two engaged in discussions that differed from their colleagues in terms of the degree of awareness expressed about wider
social issues. Although it is beyond the scope of the dissertation to consider why some nurses hold particular perspectives and not others, one factor might be exposure to alternate perspectives in educational programs. Of the remaining ten nurses, only one had undertaken university courses toward a BSN degree. (As it happened, this particular nurse had dropped her degree program, in part, because of her lack of interest in the First Nations content emphasized in courses). To move beyond speculation, future research will be needed to examine the range of experiences and knowledge that give rise to varying constructions of First Nations people.

First Nations Nurses: Interpretive Frameworks and Lived Social Experiences

First Nations and Euro-Canadian nurses spoke from markedly different frames of reference. Although both groups of nurses raised many of the same points, First Nations nurses consistently located these within a complex nexus of historical, economic, political and social circumstances. Unlike their Euro-Canadian colleagues, First Nations nurses’ identity and experiences in the wider social world shape their knowledge and interpretation of First Nations people and wider Aboriginal-state relations.

As First Nations nurses discussed their experiences working with First Nations patients, they contextualized their views by drawing on personal, everyday experiences with racialized tensions. One nurse described how, when she enters a store or other public venue, her ‘Indianness’ and the assumptions that accompany that designation often predetermine the manner in which she is perceived and treated. Sensitive to images that contribute to negative stereotyping, this First Nations nurse wrestles with her frustration at being treated as Other:

RN: I think, well in society, to me, I notice that, and from experience, that Natives aren’t really looked at to be smart. They are not looked at to be successful in
anything…. And so, I was actually talking to other nurses about this because they were asking me “how do you like [the city]?” and I go “I don't.” And they said “well why not”? And I told them my experience, like I go into a store and you know they look at me, like I am not welcome or something. You know there is just a difference. People do treat Natives different here in [the city]. Like they probably do all over the place, but I notice it more here. And then there were some nurses saying “well when you see a Native, that's what you see, a Native.” And it is hard to see behind that. And they said, “well you see the Natives here, they come up and ask you for change and stuff like that” and that's what they said. That is what they see when they see Natives: someone that is down and out, you know.

Hesitant to label her experiences as stemming from racism, she gives careful consideration to her experience:

Like, I don’t like to say “oh you don't like me because I am Native.” I don’t like to point that out right away. I think well maybe she is having a bad day or maybe she doesn’t like what I am wearing….I try not to point that out right away, but it is really hard not to when, especially if there is a customer before me and they are so nice to that customer, and that customer is non Native and then they treat me different all of a sudden, then that kind of, “well [laughs softly, briefly] I think she might be racist.”

Not unexpectedly, First Nations nurses were more likely than their Euro-Canadian colleagues to see – and experience – racialization in practice. Cumulative experiences provided First Nations nurses with “a special form of political knowledge” and insight about ideological assumptions shared by the dominant majority (Essed, 1991, p. 74). For example, First Nations nurses are frequently reminded of the commonly held stereotypes of Aboriginal
peoples as undeserving dependents. These comments are part of the everyday conversations in their communities:

RN: All over in schools you hear it...and there is that immediate difference you see between them and us. It is things that Natives get and it's all of a sudden you are not on the same ground and so you have to be separated. And I think, we went through, I went through that in high school.

Aware of the pervasiveness of popularized, colonizing images, First Nations nurses described their heightened sensitivity to behind-the-scenes comments at the workplace, as this nurse discussed:

LPN: It is really sad. As a matter of fact that’s, let me see. It is really hard for me to talk about that, because it has happened at work and the thing is it is said in a way such as “oh, this person needs to be on the phenobarb protocol,” and you know who they are talking about and it is Native. Well phenobarb protocol means, to me, all Natives are drunk. Okay? And the other racial overtones that I’ve heard just as I was there charting, something about, drugs. “They can go down to the drug store and they don’t have to pay for their drugs because they are Native,” or “they are on welfare” or something like that. Or this one, “oh he can have all kinds of medication because it is all paid for.”

What may not have been intended as racializing comments are interpreted as such.

Comments that may be uttered in a flippant tone are not considered trivial. On the contrary, First Nations nurses find these comments distressing:

LPN: There have been a few comments that have been made within the nursing unit right at the nurses’ desk and I have heard it and it has hurt me at times and I think to
myself, you know it shouldn’t bother me. But the thing is when you go down to the root of it, there is discrimination. There is racial prejudice on that unit as we speak. Even the head nurse has said one or two things, you know not directly at one particular person, but has said it in a general sense. And I don’t respond to those. I do not acknowledge those kind of remarks because uh, I don’t want to be, this is where I work. I don’t need this kind of stress.

Although frustrated with underlying negativity toward First Nations patients at the workplace, First Nations nurses realize that repeated contact with indigent or addicted patients contributes to negative stereotyping:

RN: I also see the Natives not – I just – they are not clean cut and you know. They don’t have to be clean cut, but they don’t look, like their clothes are grubby, and I understand that, like even I wouldn’t just be openly friendly to that person either but at the same time they do deserve some respect. And in [a large urban city] there’re a lot more successful Natives. Like I have run into so many that are, like artists and you know, we go to the Indian center a lot there. Like there are a lot of successful Natives there and I see them a lot but here there are not so many.

As her Euro-Canadian colleagues do, this nurse discusses the prevalence of substance abuse and “the whole range of abuse,” however, these are contextualized and socially located rather than presented as evidence of Aboriginal peoples’ incompetence and irresponsibility. She provides a context for understanding how some First Nations people come to find themselves living at the margins of society:

RN: You know, even though they might be doing drugs or they’re alcoholics, they still have feelings and there is something behind their actions. Like there is a lot that
goes on in the Native community that doesn’t get broadcast to everybody. Like I know where my mom is from, there is so much molesting going on, and all kinds of abuse. Like, all, the whole range of abuse is going on, and that is why a lot of people drink...Like they don’t know how else to deal with it. Like they see their parents drink, and they see how their parents react to stress, and that is what they do as well. They just need some extra help, and sometimes extra help just doesn’t happen. You know?

By focusing on underlying social circumstances, rather than on behaviours, First Nations nurses interpreted patients’ health care decisions in complex ways. A First Nations nurse described her own growing awareness of the complexities underlying some women’s actions in relation to their hospitalized children.

LPN: I just remember the twins. They were both in with a respiratory virus and the mom would just drop the babies off and leave, and it just really bothered me but some of my reading, and exploring, and talking to people. You know it kind of showed me that a lot of times in their mind, you know, in some instances they do have the mindset that you are the authority, right? You drop off your child because they are sick and your doctor says this is what you need to do. They are the authority. You know, you don’t, I think a lot of it is conditioning, not to question what the health care system says is best for the child. So they drop it [the child] off thinking, you know, what is best. You will take care of my baby, and I will come and pick him up when he is done. Or on the other hand look at this young mother with twins. Someone else is taking very good care of your baby. Why not? Take a few days off, and take care
of yourself. You know it is not like the children are going to suffer any from it, right? They are being taken care of.

Instead of judging this mother’s actions as negligent, the circumstances surrounding her decision are acknowledged and factored into the nurse’s interpretation; a multilayered analysis is applied.

Recognizing that the hospital is not a neutral zone, First Nations nurses described an added sense of responsibility to “try harder” when caring for First Nations patients. A First Nations nurse explains the sense of purpose she brings to her work:

RN: Yah, I cared for a lot. Well, I am First Nations myself and I think, like for me, when I see a Native person, I, like this is, when I started school this is what I had in my mind that “I am going to be a nurse so I can help my people up north” and stuff so it kind of gives me a little push I think, to try harder and stuff. Like I do try hard for every patient but when I see a Native person, you know, I hope that they will have trust in me.

Personal experiences in the social world create strands of shared understandings between nurses and patients. Assuming that patients want to avoid potentially dismissive glances, gestures or remarks, First Nations nurses implicitly understand why First Nations patients and visitors may seek them out – even when assigned to another nurse:

RN: And then even, if like the Native patients, they have their relatives come. They come to me first because they see, I guess, I don’t know, it is because I am more approachable. Like I am more nice and more calm and gentle than some of the nurses. Like some of the nurses are really strict and abrupt, and stand their ground, but I am more lenient [laughs briefly].
A: And, uh, why do you think patients do come to you? You mentioned because you might have a softer manner?

RN: Yah it might be that, or it could be that I'm like the Native patients. Like when I go somewhere and I see, like if it is just a store, a clothing store and I see a Native working, I would probably go to the Native person, because I know we can communicate. Like, I know how some Caucasian people treat me and it is not so nice so I don't want to, I want to stay away from that. I go to someone that is, yah, more accepting.

**Summary**

Intending to provide the best care possible to culturally diverse patients, nurses draw on a variety of disciplinary theories and discourses. The analysis in this chapter illustrates how these theories and discourses, while well intentioned, inadvertently construct Aboriginal peoples as dependent Others. In the absence of alternate analytical perspectives, dominant discourses which continue to re/present Aboriginal peoples as inferior Others are taken-up even as they contradict professional discourses of egalitarianism and cultural sensitivity. First Nations nurses, whose social locations and experiences diverge so significantly from their Euro-Canadian colleagues, bring a profoundly different analytical lens to their work with First Nations people. This does not imply that First Nations nurses rise above or suspend the assumptions embedded in dominant and professional discourses: rather, these discourses are differently positioned and privileged within layers of knowledge formed by their experiences as First Nations women.

This chapter has illustrated the ways in which varying frames of reference shape nurses’ attitudes and knowledge of First Nations people. A critical question is whether or not
practices with First Nations patients are affected. This question is addressed in the next chapter, as I examine the extent to which nurses' interpretive lens and presumptions shape encounters with First Nations women in the hospital.
CHAPTER SIX
EVERYDAY ENCOUNTERS BETWEEN NURSES AND FIRST NATIONS WOMEN: HOW FRAMES OF REFERENCE OPERATE IN ROUTINE PRACTICES

Introduction

In this chapter, the focus of analysis shifts to nurse-patient interactions and how nurses’ understandings of Aboriginal peoples shape the tenor of their interactions with patients. To organize the analysis, I pose one central question: to what extent are assumptions about Aboriginal peoples made visible during everyday interactions in the hospital? Using examples from interview and observational data, I examine how assumptions about Aboriginal peoples, culture and differences are interwoven and reproduced in routine interactions, organizing the relational aspects of nurses’ work. The term relational is borrowed from Susan Sherwin (1998) to refer to “the full range of influential human relations” both interpersonal and public (p. 19). “Relational selves” are not static or fixed, rather, they are “significantly shaped and modified within a web of interconnected (and sometimes conflicting relationships)” (p. 35). By politicizing the term relational, the political dimensions of the relationships that structure interactions between people are emphasized. This reading of relational counters notions of relationships as purely private and free of political influence.

As the analysis unfolds, it becomes apparent that both nurses and patients bring assumptions about how each will react toward the other. Positioned within historical patterns of relating and one’s own social, professional and cultural location, deeply ingrained assumptions about the Other can create a climate of skepticism and obscure points of connection. Anticipating, maneuvering, and sometimes guarding against how the Other will
react adds to social distances as nurses and patients become entwined in their historical positioning. Examining the complexities of nurse-patient interactions must therefore consider that, “At any moment the relationship of a health care provider and a patient occurs in the context of numerous cultural possibilities” (Reimer Kirkham et al., 2002, p. 227).

There is a caveat that I wish to raise for the reader. The focus on interactions comes with the expectation that observational data will be used to illuminate the arguments. This is true where possible. The reality of nurses’ work, however, tremendously limited the time that nurses could actually spend interacting with patients. The lack of direct interactions with patients, except when the more necessary care was delivered (e.g., when medications or treatments were delivered), was unanticipated. At this hospital, nursing care was organized around teams, with licensed practical nurses conducting the majority of assessments and treatments, and registered nurses responsible for delivering medications and more complex nursing interventions. As nurses were approached to participate in the study, most were concerned that “there would be nothing to observe,” anticipating that they would be spending only fleeting moments interacting with the patient assigned to them. Indeed, in a four hour observational session, the registered nurses I shadowed sometimes had no contact with the patient. In most instances, nurses “popped in” to their patients’ rooms to give medications, ask a brief question, or impart quick instructions. Opportunities to connect with patients were infrequent, but did occur with some patients as nurses gave medications, changed IV bags or dressings, or conducted brief assessments. As I explain later in this chapter, points of connection were more easily established with some patients than with others. For the most part, however, nurses’ interactions with their patients were brief and minimal. The analysis I present is therefore informed by observational data where possible, and by nurses’ accounts
of their interactions with patients. Observational and interview data therefore provide two angles from which to examine nurse-patient interactions, providing a more complete picture than either might provide alone.

**Responding to Difference: Quiet Patients**

Despite nurses’ commitment to the ideals of egalitarianism, several Euro-Canadian nurses acknowledged how difficult it was not to see First Nations patients as different. A nurse explained:

RN: You try not to make a distinction but sometimes you do see, that is, the first thing that you see is they are Native.

Drawing on binaries to distinguish between “their” and “our” styles of interaction, the nurse explains how she alters her approaches in response to these differences:

RN: I think I am quieter with them. My approach is quieter because I’ve – Natives tend to be more quiet, quieter. Then there is the other, the other type that are angry with White people so you do approach them differently in the fact that you don’t talk to them as much probably, or I know I never did, and you don’t uh – there isn’t that touchy [touchiness], like there is with the other.

In addition to changing her style of interaction for quiet patients, this nurse braces herself against those patients or visitors who may be “angry types”. She goes on to explain the circumstances of her encounters with angry patients:

A: I am interested to hear about how you can tell when some patients or families are angry with White people.

RN: I think it is their body language. And how they, you know when you are trying to build a relationship with a patient and how they react to you. You can always tell
that they're quieter. They don't answer you, or it is monosyllables, like single
sentences kind of thing. It is not – they never come out and say it. Once and a while
they do, if they get really angry with what they think the care is given to their loved
one, especially with the elders. The family will come in and be very angry with how
they feel, what's going on, and they are more verbal that way. But I have never found
Native people to be verbal with you. Like say the White person: they think nothing of
saying exactly how they feel which blows my mind sometimes how people can talk to
you. But Native people I never found them to be that way, except if they were drunk.
Native women, you know and then sometimes whoa, but that was more on an
outpatient basis. It wasn't when they were an in-patient.

Perceptions of difference as a metonym for Other are reinforced in both quiet patients and
angry patients. In this nurse's experience, the circular reasoning of difference is reinforced:
being angry is out of character for (typically quiet) Aboriginal peoples, particularly
Aboriginal women, unless they are drunk. Feeling that she has to determine which type of
patient she has been assigned – "quiet" or "verbal" – her ability to establish points of
connection or relate with patients is precarious. Until then, the nurse feels she must tread
cautiously.

Being verbal or outspoken conflicts with idealized notions of Aboriginal patients as
quiet. A common perception expressed by Euro-Canadian nurses was of First Nations
women as quiet, good or easy patients. These were understood as cultural characteristics:

51 Henderson (2000) explains the circular reasoning of difference. Provided with repeated "evidence," what is
assumed to be true is reinforced. Knowing that group members (supposedly) have a particular character trait
resulting from their difference, health providers anticipate – and are not surprised – to observe its frequent
manifestation.
RN: Another thing with these people that is cultural, most of these women are very bashful, very shy.

Views of women as undemanding, patient, and accepting fit well with nurses’ constructions of the idealized “good patient.” For some nurses, quietness represented an anticipated, typical interactional style, a marker of difference, but not a source of frustration:

RN: She is a really nice lady, really nice. Very quiet. A very stoic type of lady. She is a very typical lady from Community A... and she is a typical you know Native lady and I don’t mean it in a bad way. You know she is just a very typical, you know, doesn’t complain. You know even when I knew she really didn’t feel like getting up, she would still get up, you know. Whereas some of the other patients, they would allow you to pamper them, but she didn’t seem to let a person do that. Very independent, very used to doing things on her own.

For others, quietness invoked stereotypical images of First Nations women as passive, simple, and dependent. One nurse explains her frustration:

RN: To assess a pain level with a Native person is difficult. You have to look for a lot of things other than them telling you, because they don’t. And the women too. They will come in downstairs and you ask them how they are doing. They say fine they don’t show any signs of being in pain or anything and then they will get up and go the bathroom and deliver a baby in the toilet. Like, you have to use a lot of different assessment tools because not always will they communicate with you verbally so you have to use your vital signs, you have to watch them, because they just won’t tell you and they won’t make eye contact when you ask them. And if you ask them point
blank they will sometimes shrug, they will sometimes grunt or they will say I am okay. But are they okay? You are not always sure and the idea is different.

Locating these interactional differences within culture provides a way for nurses to frame their frustrations:

RN: But particularly I find with the First Nations because a lot of them are very quiet. I had this one in there and she wouldn’t look at me. She wouldn’t answer anything. She would nod occasionally. She really didn’t know what was going on with her so I got the Aboriginal Support Worker and she spoke to her. I mean it is a cultural thing. She is from the wok-wok [referring to a remote community] way the heck and gone, and she has never had to deal with anybody before.

Reticence is an understandable source of frustration when nurses feel they are attempting to communicate and the patient does not respond in turn. The issue I wish to draw attention to is not whether First Nations women are or are not quieter than other patients, but rather, the extent to which essentializing images produced through discourses of culture can set the stage for health care providers to relate to patients as objectified Others (Anderson & Reimer Kirkham, 1998).

The nurse above is not intentionally attempting to construct her patient as the cultural Other. The uncritical cultural model, however, does not extend to a critical analysis of the ways in which historical power relations frame current relations in health care. Most health professionals are not aware of the extent to which health care institutions continue to represent the recent colonial past (O’Neil, 1989). While First Nations nurses take this knowledge for granted, most of their Euro-Canadian colleagues have not been exposed to
these perspectives. A First Nations nurse explains how, for some patients, quietness stems from long-standing paternalism in health care:

RN: I don’t know. I think that, this is just a little thought I had. About Natives being passive, I think that stems from this, again, it is part of learning the history and whatnot. It stems from Natives being dictated to and being told where to live, how to live, and basically what to eat, and how to speak, and what language they’re going to speak, and that has gone on for so many years, and that is changing. And that is just another process we have to go through.

Another First Nations nurse adds to this discussion:

RN: And then also the passive…Natives being passive because they always say the doctor knows best or the nurse knows best. They [health providers, in the past] told them what they needed to do to become healthy and that is a big thing too.

What might be assumed to be a cultural characteristic takes on different meanings and significance when viewed from a historical perspective. N\textsuperscript{52}, a First Nations woman who was confident about “speaking up” for herself in hospital, contrasted her sense of assertiveness with her elderly mother’s quiet, passive manner:

N: I know a lot of Native women especially don’t want to say anything, don’t talk. I mean my mom used to be that way. Quietly. And they would take care of her and everything….I don’t know, I don’t know what it is. I don’t know what her fear of people was. Like why not just say how you feel? I know a lot of Native women, just quiet. And I mean I have seen a lot of nurses try and work with Native people and just, it’s hard because they just don’t want to talk for themselves. So then to explain

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\textsuperscript{52} Initials (randomly selected) are used in place of names to refer to the First Nations women who were participants in the study.
pain or to, you know, sometimes you have to explain where it hurts or how it hurts or things like that and it’s just a miscommunication and I think they get really intimidated by, I don’t want to say White, by non-Native people. Yah, they are afraid. I know my mom had a lot of fear in her from residential school. I know that, I remember that and sometimes she did talk about it but, maybe you spoke when you were spoken to and things like that. And that is pretty well the way she brought us up. I don’t know what happened to me. [laughs for a moment].

Nor does quietness necessarily signal intimidation, as one First Nations nurse explained.

RN: And the quietness. I don’t take that as being rude when they are quiet...Yah just, like just you being there, they know that, doing stuff for them they know you care. Like if you just go in and out, they think oh that person doesn’t care. Like you don’t even have to really say anything, if you’re just doing stuff for them. Yah. And then whereas I go into another room and they want you to talk to them. They want to ask questions, like a non-Native person, and if you don’t they are like “oh you are quiet” and, yah, they really point it out.

A: Yah. And I think that some non-First Nations nurses then, feel a little bit uncomfortable with the quietness of some of their patients.

RN: Yah, even with me they are like “you are so quiet.” And, well, I’ve got nothing to say and I will say something if I really need to.

When dominant styles of interaction and social exchanges are taken to be the norm, alternate interpretations of quietness are not considered. Dominant, Eurocentric conversational styles are expected, despite professional discourses that recommend cultural sensitivity. Patients
whose relational approaches differ – those who do not speak up – risk having their needs overlooked or neglected. A Euro-Canadian nurse explains how this plays out in practice:

RN: If a patient doesn’t ask, it is pretty well assumed that by default they know what is going on. Yah, we are just too busy. We are, we are too busy unless somebody specifically asks you.

Even when the relational rapport between a nurse and patient may be comfortable, as observed between a particular nurse and H, an elderly woman who was her patient, constraints on nurses’ contact with patients limit opportunities for patients to initiate a dialogue. Because of her hectic workload, H’s nurse spent only a few seconds interacting with H during a four-hour observational session. Patients who do not take advantage of these opportunities to pose questions or raise concerns get lost in the confusion:

RN: Yes she [H] was very reticent, didn’t complain, didn’t say much or something would sometimes come out just sort of in passing if you will. We talked about something and I said, “well, you didn’t tell me that.” “Well I [H] didn’t think it was important.” Then you find that happens quite often. They just kind of smile, you know, so sometimes I think that is what happens too. Often the patients themselves don’t want to say and a family will come on almost too strong because they feel that their family member was being neglected and it is because the patient them self hasn’t said anything. And it is very easy to pass over something when you are so busy because if somebody doesn’t demand immediate attention on a really busy day, they are going to be, not forgotten, but their issues are not going to be addressed because they haven’t presented any and you have two or three people down the hall that are taking every minute. So I think that is often what happens....I could go on forever
and I am just saying there is often so much confusion...so much gets lost in the shuffle.

When historical relations of power and paternalism come into play, dialogues are further inhibited. While nurses expressed concern about “missing something” in these situations, responsibility for communicative engagement remains with the patient. Patients who do not speak up unwittingly become the authors of their own misfortunes.

The Significance of Informal Social Dialogues

Understanding the function of informal social conversations is helpful to this analysis of relations between nurses and First Nations women. Sociologist Erving Goffman (1997) defines “small talk”:

It is as if society had set aside certain topics as ones that everyone is expected to have an opinion on, that are to be held in relative readiness and to be brought to mind quickly, that are not defined as part of anyone’s protected lore (and therefore can be addressed by social inferiors), and that are seen as requiring no special competence or experience. Small-talk topics, then, mark a socially sanctioned opening between minds. (p. 198)

Applying Goffman’s ideas, social exchanges between nurses and patients can be understood to indicate social inclusion and recognition of shared perspectives. Presuming a reciprocity of perspectives⁵³, nurses in this study slipped easily into brief social conversations with some patients, but not others. A careful analysis of observational data revealed that such interactions occurred less frequently, and often not at all with First Nations women. Here I

⁵³ Furniss (1999) drew my attention to Alfred Schutz’s (1962) notion of a “reciprocity of perspectives” to explain shared, common-sense knowledge in the context of phenomenological philosophy (Schutz, p. 11). As Furniss explains, social constructions of common-sense knowledge depend less on shared worldviews and more on “the presumption of a ‘reciprocity of perspectives’ among those with whom one associates” (p. 118).
am referring to the few minutes that nurses spend “chatting” at the beside with patients and visitors about non-clinical topics – knitting projects, the weather, grandchildren, local craft fairs or politics. These social exchanges occurred fairly routinely as nurses interacted, albeit briefly, with Euro-Canadian patients. However, in my observations, such exchanges occurred only twice during interactions with the First Nations women involved in this study; in both cases, it was the women who initiated conversations about family-related or personal aspects of their lives with their nurses. The point here is not to suggest that nurses are consciously distancing themselves from First Nations women. Rather, social distances observed between Euro-Canadian nurses and First Nations women stem from presumptions that there are very limited points of entry for relating with First Nations women.

Excluded from the discourses and vocabularies of the dominant society, First Nations women can be overlooked as competent social players. Of what consequence is this form of exclusion? I argue that emotional support, concern and caring typically conveyed to patients during brief social exchanges – through joking, small talk and the exchange of pleasantries – is less often established with First Nations women. In turn, the potential to engage in the emotional labour\(^\text{54}\) of nursing is diminished (Varcoe & Rodney, 2002). Social distances widen and opportunities for reciprocal exchanges decrease as women are viewed as being so different or so Other as to be beyond the reaches of routine social interactions. Whereas First Nations nurses try harder, Euro-Canadian nurses may presume that the extra effort required to connect with a First Nations woman – who may be perceived to be too quiet, angry, or culturally different – is unwelcome or futile.

\(^{54}\) The emotional labour of nursing – as opposed to bodily, physical care – is defined by Varcoe and Rodney (2002) as the work required to deal with patients’ and family’s feelings, emotions, fears and worries, and promote the emotional wellbeing of patients.
Acting on Presumptions of Otherness

Several Euro-Canadian nurses described their difficulties assessing and responding to patients' expressions of pain. Presuming that women's expressions of pain will differ from the norm, a nurse described the challenges she perceives:

RN: Well, this is what I find, that some patients, the Natives, have a propensity to like the narcotics – the Native patients more so, they seem to really want that. It's sad, but that is just the way it is. [Field note entry].

She explained:

RN: I have trouble with First Nations as far as trying anything [for pain] other than the real thing, you know. I'm trying to get into breathing techniques and different techniques for pain relief. They don't believe it, which I find interesting because I always thought that dealing with the earth and the mother earth made far more sense than what we do for religion but they don't. They are very different. They don't believe you and they won't use it. So you are basically left with drugs and when they want them, they want them.

The assumption that First Nations patients would naturally embrace alternative, natural or holistic therapies stems from popularized images of Aboriginal peoples as spiritualized Others. Opportunities for patient teaching about pain control are discounted as being irrelevant. These expectations are borne out in relation to C, a 25-year-old First Nations woman who underwent surgery two days before the observational session. The nurse shared her views with me as we walked to C's room, saying "What we have here is a Native lady who has a very low pain threshold" [Field note entry]. Embedded within this statement is an implicit skepticism about the veracity of C's requests for pain medication. There were no
obvious delays in the delivery of pain medications; however, C had concerns about her pain management. Her initial comments to me were:

I'm having lots of pain but they won't give me anything now. I was on morphine but they said no, I can't have it anymore. And anyway, it made me sick to my stomach – I vomited after it and that really hurt. The doctor was just here and I told her but they won't give me anything besides Tylenol #3 and they aren't doing much. I think they should give me Demerol but they won't. [Field note entry].

The point here is not whether C's pain was legitimate or not; rather, I wish to illustrate how easily nurses’ assumptions about Aboriginal women’s pain tolerance can be reinforced. Observational and interview data also indicated that C fit the nurse’s notion of women who are typically dependent and irresponsible. From my interpretive perspective, the nurse’s mannerisms also conveyed a disinterest in connecting with C. For example, observational field notes recorded my impressions as C’s nurse disconnected her two IVs:

The nurse came over to C's bedside and without saying anything to either of us, started taking down the IV bag and disconnecting the IV pump. After about one minute, as she was handling the IV tubing (and without looking toward C) she said, “you’ll be free of this now.” It seemed to me that C did not hear what was said – she looked at me with a confused expression. The nurse repeated, as she pulled the IV pole away from the bedside, “you won’t need to take this with you now.” She then lifted C’s arm, and without saying anything, started pulling the tape off of her arm. C looked a bit concerned as she watched the nurse pull off the tape. I remember thinking, “she isn’t explaining what she is doing, she’s just going ahead and doing it.” C then lifted the other arm in the air, as if she were asking a question in a classroom,
and said, what about this one? [referring to the 2nd IV line]. The nurse responded, “Yah, that’ll come out too.” As the nurse’s back was turned for a moment, C started to pull the opsite [bandage] off the 2nd IV site. A few second later, the nurse turned to face C and saw her pulling the tape off. The nurse looked suddenly exasperated and said to C, in a firm tone, “no don’t do that,” then in her regular tone, “that is staying in. That’s not coming out, just the pump.” C immediately stopped peeling the tape and said, “oh okay.” The nurse looked tired, and without saying anything further, gathered up the equipment and turned to walk away.

Without doubt, there are a range of factors influencing the nurse’s manner, not the least of which may have been fatigue. It is significant, however, given the unequal balance of power and knowledge, that no verbal exchanges were initiated despite C’s question.

Misconceptions and myths about Aboriginal peoples influenced nurses’ actions in other instances. The following situations were not directly observed; rather, they were conveyed to me by four First Nations nurses. The case in point drawn on by all four nurses depicted situations in which their nurse-colleagues acted on presumptions of First Nations people as unclean, or as vectors for lice, scabies or TB. A First Nations nurse described her observations:

RN: It is if they have had head lice. It is not a routine checking of everybody. It is mostly the First Nations people. Part of it is probably because if they have psoriasis or something, you get flakes or even dandruff, you get flakes and the hair is darker. As soon as they see white flakes, they delouse them. Little things like that. We had a guy, I am pretty sure he had psoriasis on his back, last week with the same thing and they treated him like scabies, wore gowns, everything [laughing slightly]. Their mind set is
that, and they still don’t believe that they are doing anything different or anything wrong. But it is like you said, body language tells a lot. Like what is coming out of their mouth as opposed to what their body language is, like gowning up for scabies to give them a shower, but you don’t gown up for head lice. So, it’s quite interesting to see the differences. And TB, that is the other one... Automatically, coming off reserve “what is their TB status?” or if they have had a history of TB, “well did you check them again?” There is no need to. There is no outbreak.

The sense of having to protect themselves against contagions harkens back to colonizing images of First Nations women, in particular, as dirty or as living in squalor; according to these First Nations nurses, the index of suspicion remains high. Epidemiological constructions of disease patterns can inadvertently reinforce these notions. In combination, images and epidemiological facts propel some nurses to act irrationally toward some patients. Another First Nations nurse describes a situation she observed:

RN: Like I don’t know. They just, they don’t know and it is not their fault that they don’t know, they just jump and make assumptions instead of finding out, you know, for themselves. So I think that is a basis of a lot of the discrimination and it might not be intentional.... When I was on [the ward] and a little Native girl came in an ambulance from an outlying community and they said “oh she’s got lice, she’s got lice” and then all the nurses in emergency were there and they were like “oh this little girl” and they came up with gloves on and hair covers on their head and they brought this little girl up.... And they’re all freaking out waiting for this little girl with all of this lice. And it was little fuzz balls from the ambulance blanket, and they just

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55 For example, TB rates among status First Nations in BC are three times higher than non-First Nations populations (BC Provincial Health Officer, 2002).
jumped really fast, like... and they didn’t go and try to find out or anything. They just made an assumption that’s what it was. I don’t know if they said “oh because she is a little Native girl, it is probably lice,” you know. They just saw something in her hair and just automatically assumed.

Acts of self-protection, communicated through a variety of subtle and overt practices and gestures, mark the First Nations patient as Other. As I continue to illustrate, reinforced notions of Otherness contribute to social distancing. First Nations nurses were consistently clear, however, that while these situations represented differential treatment, bodily care was not compromised. Of concern, however, is the potential for these messages to undermine support that might otherwise be provided to patients. L, a 31-year-old woman who was being treated for a suspected TB infected wound, described how a nurse’s comments affected her:

L: Oh yah, there was just one nurse when I was getting ready for the skin graft, she kind of talked down to me but I just ignored her. She just seemed kind of snippy because I think she was kind of looking at my leg, that is what she said, “was I contagious?” that is what she said and I said “Well if I was, I wouldn’t be here do you think”? That is all I said. So if somebody talks to you smartass, you talk to them smartass too. But I just ignored her and didn’t dwell, because I didn’t want to waste my time. But yah, I forgot all about that....Yah, it wasn’t even in confidence, it was just right out in the open, “yah TB,” and the other nurse looked at me and there is like all these other people in hallway area too but at the time I thought, geez, you’d think they could just ask you quietly or something. I think that is what I thought, is that she should discuss it quietly and not have to freak everybody out.

Reimer Kirkham (2000) uses this term to refer to nursing practices oriented to physical-bodily aspect of care without obvious acknowledgement of the person, the context of the patient’s needs, or their lived experience of illness.
On the one hand, the nurse is required to determine if the wound was contagious. To do otherwise is to compromise basic safety. On the other, tensions can arise when nurses seem to act – and in some situations, do act – on the basis of misinformed assumptions. A First Nations nurse describes her observations of colleagues who ensure patient safety is not compromised, but who also act on the basis of misinformed assumptions:

RN: And sometimes it is not actually what is done to the patients. Sometimes it is in the nurses' office. I walk by the office and I can hear staff talking. Now if I can hear them, if a client walks by, they can hear them. I don't know what goes on beyond that as I walk by, but I know that I feel horrible walking by hearing them speaking in such a manner, and it is a lot of little things. "Oh they didn't wash their hair today."

We have one staff member that believes that all First Nations people should be showered every two days. We don't shower that often in community care, why would we shower our First Nations patients like that. And they are adamant on admission that these people get showered....But this person [the nurse] will go in and shower them, and make sure that they're safe in the shower, but they have to be showered. But they are not doing this with the White people that come in. It's only the First Nations people, which is a huge difference.

McConaghy (2000) frames these seemingly harmless actions – gowning, gloving, requiring showers, checking for lice – as part of the ways in which those marked as Other are marginalized. She writes, "Subtle means of social avoidance, exclusion from conversations, 'looks', and the countless elusive ways in which minority subjects are scrutinized in everyday activities" give rise to routine practices that objectify Others (McConaghy, 2000, p.
I argue these routine practices, informed by essentializing images and assumed cultural differences, influence how nurses relate with First Nations women.

**Negotiating Routine ‘Privileges’**

One of Essed’s (1991) central propositions about everyday racism is its potential to infiltrate otherwise insignificant situations in everyday life. The seemingly innocuous integration of varying forms of Othering practices into routine interactions activates underlying power relations. In the hospital setting, power relations find expression as routine privileges are requested by patients and (sometimes) granted by nurses. The ensuing interactions become “part of the expected, of the unquestionable, and of what is seen as normal by the dominant group” (p. 188).

Othering practices arising from intersecting assumptions related to race, culture, class and gender were perhaps most evident in the following case involving Z. Z, a 51-year-old First Nations woman, was admitted for treatment of an acute flare-up of a chronic condition likely induced (according to her) by an alcohol binge. Z lives a marginal existence in part because of unemployment and alcoholism. As I visited with her at the bedside, she described how she survives from one social assistance payment to another: a major concern was how she would be able to pick up her next cheque while in hospital. Z, who was just admitted, wished to notify her family that she was in hospital. On this unit, patients who want to make a phone call are required to use a pay phone located in the hallway. Z, however, had no coins or other cash in her possession.

Z’s nurse was a First Nations woman in her early thirties, and a relatively new employee. She intended to give Z a quarter to use the phone, but had no change. Instead, she accompanied Z to the nurses’ station to use one of several ward phones placed on the
countertop. The following excerpt, taken from observational field notes, describes the interaction that occurred as Z’s nurse asked the nurse-in-charge at the nurses’ station reception desk if Z could make one phone call.

Z, clutching her hospital gown so that it stays closed behind her back, is walking slowly, holding onto her IV pole for support. The IV pole is being pushed by Z’s nurse. Z appears tired and somewhat disheveled: her long hair is uncombed and matted in areas. Z’s nurse, with Z, approaches the nurses’ station/reception area. As they approach, slowly, the nurse-in-charge – a Euro-Canadian nurse – looks up to watch them. Z’s nurse makes eye contact with the nurse-in-charge, and says in a soft voice, “she wants to use the phone.”

Nurse-in-charge: “There is a pay phone,” speaking firmly, in an annoyed and with a flat affect, looking at Z and her nurse.

Z’s Nurse: “She doesn’t have a quarter,” softly. The patient is looking on with a neutral affect. She seems to be indifferent to this exchange.

Nurse-in-charge: To Z, “Well, okay, just this one time you can use our phone, but no more, just so you understand, this is an exception,” in a slow, patronizing tone.

Z’s nurse proceeds to pick up the handset of the phone and pass it to Z, who dials her number. As she speaks into the phone for about one minute, her voice is loud and she coughs harshly, repeatedly into the phone. Z’s nurse stands beside her and waits.

When Z is done, Z’s nurse accompanies her, pushing her IV pole, slowly back down the hallway to her room. A few seconds later, Z’s nurse quickly returns to the phone. She gets a spray bottle of cleaning solution and proceeds to wipe off the handset. The nurse-in-charge, who is still at the nurses’ station, nods approvingly and knowingly to
Z’s nurse. Another Euro-Canadian nurse who has arrived behind the nurses’ station also sees Z’s nurse wiping off the phone, and says, across the room, “I’m glad to see you doing that,” with a slight smile on her face. Z’s nurse responds by saying, “yah, she really coughed all over it didn’t she,” in a quiet tone. She then puts the bottle away and leaves the nurses’ station. [Field note entry].

At first glance, this incident may seem inconsequential. Additional contextual information, recorded in field notes, however, added a layer of significance:

What I came to refer to as the “phone incident” was all the more significant because earlier in the day, an elderly man in a wheel chair had wheeled himself to the nurses’ station and without hesitation asked the unit clerk if he could use the phone. He made his request in a cheerful manner, smiling at the ward clerk. I remember thinking that he must do this regularly: there seemed to be a type of routine in the way he confidently asked, “may I use the phone,” and was swiftly handed the handset.

In a subsequent interview, Z’s nurse discussed the “phone incident.” Her interpretation confirmed my reading of these events – that Z was given a “hard time.” She discussed her analysis:

Z’s Nurse: I was so busy but I knew that, she [Z] was there [in her room needing to use the phone]. Like I knew I shouldn’t have brought her to the desk to use the phone, but I felt that she had to tell somebody that she was in the hospital, and I know the other nurses didn’t really appreciate that, but I thought it was important. She didn’t have any money and I didn’t have any change to, so. Otherwise I would have given her a quarter and said she could use this phone out here but, yah and she was pretty sick coughing on the phone and I don’t know what she has, and so I made sure
to clean it. I noticed the other nurses were watching me and I even asked the nurse-in-charge, you know. "She was coughing on the phone, I should clean that right?" and she is like "yah." She showed what to use and even the other nurse when I was cleaning, she says "oh good, I am glad you are cleaning that. I saw her coughing all over it." But yah, I wouldn't want to use it either, after someone is coughing all over it.

A: I did notice that it was sort of like asking permission to use the phone, and I felt kind of bad, because everyone was staring at Z about whether she was going to be granted permission to use the phone.

Z's Nurse: Yah, I know. Yah, like if nobody was there I would just say "yah go ahead and use the phone" but since they were all standing there, I thought "oh I better ask because otherwise they're going to." Yah, yah, I felt kind of bad about that, because she is a patient, and she is sick, and she did have to be there, and somebody has to know that she is there because if something happens then, you know.

A: Yah. Now if there had been another nurse [at the nurses' station], would that have been an issue, to use the phone?

Z's Nurse: Yah. Yah. Um I think they would have given her, a harder time, probably. Yah. Because there was one patient, and he said he needed the phone, and he was in a wheelchair, an elderly guy and they said "yah, sure." They gave him the phone no problem. I'm like [laughs briefly, sarcastically].

Ultimately, the phone incident provides a glimpse into the workings of power relations, and how they are shaped by patients' social and gendered locations. The charge-nurse, however, did not find her interaction with Z remarkable: rather, the phone incident reminded her of
other experiences with “Native people,” who have “more phone calls than with – because it
is like third cousins are calling.” In contrast, Z’s nurse frames the charge-nurse’s response to
Z as an example of how assumptions about Aboriginal peoples seep out from behind-closed-
doors:

Z’s Nurse: I notice it like with Z, I noticed like how stern they got when I asked if she
could use the phone, “just this one time only” but they didn’t say that for the other
patient [the elderly man]. They just, “here is the phone, go ahead.” They didn’t say
“it’s just this one time only” so I notice it a little bit that they are more stern. But I
also notice too, like with my own relatives you give them a little bit and then they
take a mile. What is that... You give them an inch and they take a mile, and some
Natives do that. My own family does that to me. I help them a little bit, and then they
expect more and more. I don’t know if maybe that is where they [the nurses] are
coming from.

Not wanting to risk a one-sided analysis, Z’s nurse considers her colleagues’ actions from
various angles, turning to her own experiences with family members who ask “for too
much”. Implicit in her analysis, however, is an awareness of how her colleagues’ view Z as
an indigent Aboriginal woman. Images of A as contagious, dirty, broke, and dependent
reinforce and reproduce objectifying stereotypes. The cycle continues to build from
assumptions of Otherness to proof of Otherness. As Z’s nurse expressed in the previous
chapter, these are the situations that give rise to First Nations nurses’ attempts to try harder
with their First Nations patients.
Aboriginal Support Workers: Panacea or Paradox

The Aboriginal Support Worker provides support to in-patients and their families, assists hospital staff with discharge planning, and liaises with First Nations communities as people move between the hospital and outlying areas. Examining how nurses’ view the role of the Aboriginal Support Worker informs an analysis of how Euro-Canadian nurses respond to notions of difference.

Although the title “Aboriginal Support Worker” tags her role as cultural and language interpreter, she describes her role as largely devoted to social work. Some of the nurses who had worked in the hospital for many years described how heavily they relied on the Aboriginal Support Worker to assist with patients they assumed had complex social problems. As I observed, however, nurses sometimes acted on misguided assumptions about their patients, resulting in unnecessary use of social support services. Field notes described how a patient’s discharge was delayed for several hours while an after-hours crisis social worker (since the Aboriginal Support Worker did not work on weekends) was summoned to deal with discharge planning for L, a 33-year-old single mother (who was employed full-time at a First Nations organization in the city). In hospital, abstracted from her role as a competent working parent, L’s social situation was presumed to be difficult:

I had met L, the day before, and as it happened, we spent some time talking about how she would manage at home after discharge. From what she said to me, she seemed to have supports in place at home: a cousin who was coming to hospital to take her home, a sister who would help with child care, friends from her church who would help with cleaning and meal preparation. Because I knew of this context, I was

57 In fact, the Aboriginal Support Worker responds to few requests for language interpretation since most patients from this region are fluent in English.
surprised that the after hours crisis social worker was involved in assisting with discharge planning. As the only social worker on staff, she was called by the nurse to help “sort out supports at home.” On the day of her discharge, L waited several hours before the social worker came to interview her about her home situation. After a brief interview, the social worker, reporting back to the nurse, expressed surprise at the extensive social supports the patient already had in place. The nurse also expressed surprise as she learned that her expectations for her patient had been exceeded, saying, “Well, that was easy... less complicated than I expected!” [Field note entry].

Expecting L’s case to be complex, the nurse and the social worker were surprised to discover that L did not fulfill their assumptions. On the one hand, the nurse’s concern about L’s home situation represents a careful approach to discharge planning. On the other, by failing to check her assumptions against L’s particular situation, stereotypical notions of group characteristics were – perhaps unconsciously – applied.

In a later interview, the nurse and I had the opportunity to discuss the situation. From her viewpoint, she believed “it didn’t matter than she was Native. It didn’t matter... It was simply a difficult discharge planning that took time and wasn’t so much focused, well I don’t think, was focused at all on the fact that she was Native.” Despite her best efforts to apply a colour-blind perspective, it does, however, matter that her patients are “Native.” She goes on to explain:

RN: Now, when we get a Native woman or a man as a patient, whether it be a joyous situation or a horrific situation, we immediately call our Aboriginal Support Worker and we work from the beginning with her.
Undoubtedly, the presence of the Aboriginal Support Worker represents a significant commitment to addressing the health and social needs of Aboriginal patients and families. At the same time, the separation of Aboriginal and non-Aboriginal social work services racially marks the routine needs of Aboriginal patients. Routine discharge planning and social support, which are shifted away from regular staff to the Aboriginal Support Worker, identify the needs of Aboriginal patients as further evidence of difference. Herein lies a paradox: although the services of the Aboriginal Support Worker are vital to the wellbeing of patients, reliance on the Aboriginal Support Worker inadvertently reinforces views of Aboriginal patients as being so Other as to require a special service. This also relieves nurses of the responsibility to explore more directly aspects of patients’ lives presumed to be off limits or reserved for the Aboriginal Support Worker.

The problem lies not in the nurses’ intentions: to make the services of the Aboriginal Support Worker widely available to their patients. Rather, it is the way in which First Nations patients’ needs are assumed to be problematic. A Euro-Canadian nurse describes this view as she discusses her patients:

RN: I think the big difference I find is when you get into nursing with their [First Nations] family environment and their needs are usually a little more than other people. They quite often need social workers involved for financial reasons, like, you know, involvement with other family members because they live together in a big group quite often and a lot of times certain people like the grandparents care for grandchildren and the parents aren’t always there so when they are hospitalized, they need someone to help care for the child because they are not there. So we quite frequently get social workers involved with Native people.
These needs may be real for some patients, however, what remains unrecognized are exceptions to these stereotypical generalizations, or the ways in which needs are nested within socially organized relations.

The paradox of the Aboriginal Support Worker also lies in the hospital’s official description of his/her role: to provide “positive, friendly assistance to Aboriginal peoples and their families” (hospital web site \(^{58}\)). Emphasizing the need for additional friendliness directs attention away from the more substantial efforts required to redress differential power relations and historical patterns of paternalism, authoritarianism or intimidation influencing health care experiences. Instead, the path of least resistance is to rely on the Aboriginal Support Worker. Assuming the Aboriginal Support Worker can traverse the assumed divide between us and them, the need to interact directly with Aboriginal patients lessens. A Euro-Canadian nurse explains:

RN: You know she [the Aboriginal Support Worker] understands the culture. We like to think we do; I don’t think we do at all, really. Because I think that their culture is spiritual on every level and ours isn’t and I don’t think we really can meet the needs the way that a Native person can so therefore I find her a good ally.

Essentialized notions of spirituality further demarcate Aboriginal patients as Other.

Assuming that all Aboriginal patients will necessarily respond to the Aboriginal Support Worker simply because they are Aboriginal, another nurse describes:

RN: She knows a lot of their histories and stuff. Most of them respond to her simply because she is Native.

I am not questioning the veracity of this statement. Rather, I draw attention to the assumptions fueling the nurse’s perceptions of Aboriginal patients as necessarily responsive.

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\(^{58}\) The web site remains unnamed to maintain the anonymity of the research site.
to the Aboriginal Support Worker, and conversely, as largely unresponsive to the efforts extended by non-Aboriginal nurses.

In contrast to previous Aboriginal Support Workers employed at the hospital, several Euro-Canadian nurses found the current Aboriginal Support Worker easy to relate with:

RN: She doesn’t make a big deal about being First Nations. She doesn’t kind of shove it in your face. She tells some pretty good jokes too. She is just there for you. And it is so much easier to deal with her. I found it very difficult to communicate with the other two [previous Aboriginal Support Workers].

The past Aboriginal Support Workers referred to above, whose communicative styles, accent and dress were more similar to some of First Nations women from isolated reserve communities, were thus marked as socially, linguistically and culturally different and less approachable. In contrast, the nurse continues to describe her view of the current Aboriginal Support Worker:

RN: She [the Aboriginal Support Worker] is not all the way over there for First Nations. She’s realistic. She knows there are problems with a lot of the younger ones [patients] with the drugs and the alcohol and she is very aware of it and she doesn’t try and hide it or make excuses for it.

Categorized as someone who is not like Other First Nations people, social connectedness is established with the Aboriginal Support Worker, but not necessarily with patients.

Locating the Context of Mutual Mistrust

Situations that carried a potential for tension occurred when First Nations patients had numerous visitors in attendance at their bedside. Nurses recognized the importance of visitors to their patients’ wellbeing and made efforts to accommodate visitors. At the same time,
pressures rose as they attempted to provide bedside care in crowded patient rooms. One nurse described the dilemma created when family members were present:

RN: There is a whole cultural thing about First Nations individuals: they love to have their family around. I think it is very important to their health and I understand that. And I think most of the nurses on the ward understand and felt that, yes, it was important to have the family there. Yet on the other hand when the family was there, things were very disruptive and that it was very noisy. It is difficult sometimes to do nursing care with so many of them around, and they often stayed well into the night.

Interacting with visitors who traveled in to the city from outlying reserve communities was more complex when nurses were sought to sign documentation required by visitors to receive entitled travel reimbursement. In some situations, visitors fulfilled nurses’ assumptions about First Nations people as dependent Other:

RN: For instance this one delightful elderly lady that I was caring for who died in our care actually. Her family came to town and on the second day that she was there, several young people in the family presented these letters that they wanted me to get the doctor to sign because if you sign these letters, their being in town would be paid for, and they were inebriated and it was like "go away." Like you’re not, you’re not, like, if you were here, as many of that family were, as a caregiver or even mounting a vigil, then definitely I would be all for it. But to know that you could just get this letter signed and whatever part of the, and I don’t know a great deal about the, how it works, I really truly don’t, I just call the Aboriginal Support Worker. But anyway, they had that expectation. Just to me, it was a different reflection then, and you know
if I were going to visit an out of town relative, I would be on my own, sort of thing, you know.

Although most visitors do not come to the hospital inebriated, those that do rouse powerful negative reactions and images for some nurses. While describing the situation above, the nurse recalls a vivid childhood memory. According to her, at that time, a northern First Nations community had recently been given a "money settlement that had worked out to be almost a million dollars for every Native in the area":

RN: There were Native people drunk, unconscious, on the streets, urinating on the streets, copulating on the streets. Before that summer was gone, the money was gone and so there was no gain. So I do find that right now I think we simply look after Native people on all levels. And that memory I have from Community B certainly holds that up to me.

This visceral portrayal contains vestiges of past colonizing discourses that used zoological terms to describe indigenous peoples and reinforce their position of inferiority (L.T. Smith, 1999). Without realizing how damaging these images have been, and continue to be, past memories shape current stereotypes and continue to inform the nurse's interpretive lens. Past encounters with inebriated visitors continue to feed nurses' suspicions, as another nurse described:

RN: I had already dealt with one bad situation. In previous situations quite often this culture, they do drink a lot and I didn't want to allow other people [visitors] to come up [to the ward] in the same situation and deal with them again.
Framed as a cultural issue, the significance of substance abuse as a manifestation of wider social problems is diminished; instead, substance abuse is re/presented as an almost inevitable part of their culture.

Assuming that issues stemming from cultural differences are at play, nurses find it difficult to understand why visitors may respond with hostility when they are asked to leave the hospital. From the nurses’ perspective, requesting that visitors leave is done to preserve the energy of their patients. These requests, however, can backfire. One nurse explains a situation that periodically arises:

RN: I know the one thing that we deal with quite often on our ward is the number of visitors people get. Native families have, like they’re big families, and quite often you get several people visiting and we have visiting hours in the hospital. And quite often they visit early when they are not supposed to be there and you have to ask them to leave, and a lot of people have, some people have problems with that, like they think you are being prejudiced but you just have to explain to them that it is nothing against you or your race, your culture....I mean if there are particular incidences where they need to be there, we let them stay. We take different things into account but I think they are big families.... I have had people say you know, you just want me to leave because I am Native or you don’t want me to be here because I am Native or, and I am just honest with them. I said I have nothing against your culture. I said if you were a White person visiting a White woman I would still ask you to leave. And I just explain to them the reason why, you know, the same as I would anyone else. So you just have to reassure them that it is nothing to do with the fact that they are Native or you have a problem with them. And once you explain that
to them, they are usually, I have never had people that make it a really big deal. They usually understand and then they go.

A: I just wonder if you have some kind of sense of where that comment comes from?
RN: I am not quite sure where it comes from. I don’t know if they get a hard time frequently from people. Like I am not too sure where, I mean obviously the comment comes from something in their past, to think that someone would be, would be that way so I am not too sure. And I never ask, I just try to diffuse the situation and explain that is not what is happening, so what is behind it, I am really not sure. I don’t really get into that with them because then you are opening a big can of worms for nothing.

The nurse understands that there must be “something in the past” that triggers visitors’ reactions. However, without understanding how wider, socially organized forms of racialization, marginalization and oppression operate in everyday life, it remains difficult to locate visitors’ reactions in a wider context.

This study did not set out to focus on trouble cases or critical incidents, nor did observational data capture the moments of tension described above. Significantly, First Nations women did not raise these issues as concerns arising during their most recent hospitalizations. Yet nurses repeatedly described the need to be alert for “the type that are angry with White people...And sometimes it is wrong, but you just assume because they are Native they are going to act that way.”

It is not just Euro-Canadian nurses who become caught up in this complex interplay of social and historical positioning. A First Nations nurse – who, because of her outward appearance says of herself, “most people don’t know [I am First Nations]” – was also the
recipient of families’ frustrations. On these occasions she too was told she was acting in a discriminatory manner. She describes the context of these encounters:

RN: She [the family member] just yelled at me and said I was making her leave because I was racist and didn’t like Natives. I got a little offended at that. And another woman who basically [said] the same thing. They were asked to leave a particular area that was designated for nurses only. Same thing racism, racism, racism, and that made me mad too because like well “Hello!?” Don’t accuse me of being racist, but then, those are also families who are dealing with the potential loss, or really, really sick family members and both instances they were both very sick family members and they were in that middle aged bracket. They were both women, and I think they were just very; you don’t know what their history of dealing with the health care system has been like...And I just told her [the family member], I said “I am First Nations and I am not asking you to leave because of your race and I am offended that you are accusing me of treating my patients differently” and the patient was just mortified. She said “oh no,” she said “my sister is just upset. Just ignore her” and telling her sister just leave, just leave. The patient was quite mortified. I think she was very embarrassed...It might not have been what I said because, you know you have to be very careful what you say to people. I think my demeanor was probably not appropriate.... And so the other lady, afterwards she came up to me and gave me a big hug and said I am very sorry. I said I am very sorry. Maybe we were just miscommunicating and yah, it was very nice. Again she was upset. Her mother was very very ill and she actually died a few days after that. So you can understand so, unfortunately I do take it personally and I am trying not to.
She considers why some families react in this way:

RN: I’m only guessing that perhaps these individuals have not been treated well by the health care system. To me it just seems like they are automatically defensive, like, they’re, you know, they are just waiting for the attack to come. I mean you can almost see it in the way that they stand and you know I am only guessing. I would just assume that it is because of maybe a past bad experience.

Liberal notions of reverse discrimination also frame some nurses’ frustration with patients’ claims of discrimination. A Euro-Canadian nurse explains her perspective:

RN: I don’t feel I discriminate against different cultures but I have had experiences where the cultures feel they are being discriminated against. They come in with this preconceived notion. They have not had any experience. They are just right away, you know, “you are discriminating against us.” Blah, blah, blah….But I don’t feel I discriminate, but I do get a lot of people that feel we do discriminate against them. I feel from other experiences outside of the hospital and they are always sort of on guard or always play that card you know.

The sense of mutual mistrust that can unfold in some situations is described by this Euro-Canadian nurse:

RN: And if you go in with an attitude that “I am going to tell you what to do” and “you are going to do it,” a lot of them will just get their backs up. Because a lot I have run into, well I can’t say a lot, maybe about a tenth of them, don’t like us, at all and resent us, and they are very difficult to deal with because they think we are doing things to harm them. You know it’s been inbred in them very young, I think the hate
the same thing we are dealing with Bin Laden. You know, people are brought up to hate, but you can get around it usually.

Unaware of the social and historical contexts of tensions that can erupt as patients/families and nurses react to one another, the two nurses above frame these hostile reactions as individual choices: “inbred to hate,” individuals choose to “play that [‘race’] card.” Situations of mistrust abstracted from their wider contexts thus erase the significance of past histories, stereotypes, and assumptions that can play out in routine interactions.

As these excerpts illustrate, situations of mistrust operate as two-way processes; nurses and patients can both become tangled in past histories and stereotypes. How nurses or patients interact with the Other must therefore be interpreted within wider histories and relations of power that accrue from past experiences and the background knowledge that each brings to an encounter (Anderson et al., 1999). As McConaghy (2000) writes,

> It is no longer always useful to present dichotomies of the coloniser and the colonised to illustrate the differential power relations and life experiences of those in colonial contexts...An important task is to better understand the specific nature of specific oppressions at specific sites: to understand current forms of oppression. (p. 8)

**Seeking Points of Connection**

As I have argued, the interactions between Euro-Canadian nurses and First Nations women that I observed were characterized by observable social distance. There were, however, exceptions: separate interactions involving two nurses were qualitatively different from their colleagues'. During my conversations with these two nurses, generalizing statements, for example, “they are usually really nice to work with,” did not give way to the kinds of objectifying negative images unselfconsciously expressed by some of their
colleagues. During observational sessions, their non-verbal gestures, body-language, and verbal exchanges with patients seemed to create, rather than shut down, points of connection.

One of these, a Euro-Canadian nurse who provided one-to-one care to patients in an outpatient clinic at the hospital described how letting her professional guard down seemed to help traverse relational distances:

RN: Well, I guess from my experience I think that the first thing you have to do is not come across as this nurse professional person and not a person that absolutely knows, knows it. I often find, I usually sit and feel them out and just see where they are at and what their knowledge level is. Because many of them have a lot more knowledge and will not share that with you....The one thing I have always found is that I just don’t sit there and say I am better than you and I know more than you because I happen to be a nurse. I have learned that over the years. It just doesn’t work. It just will not work. Because if you walk in and sit there, and I just found once you get, if you get a barrier there, that barrier is there forever. If you put that barrier down, you have got a friend forever. ...Don’t put them down. Like don’t make them feel less of a person just because you are educated. I think that’s what I am trying to say maybe.

Unlike her colleagues who worked in in-patient settings, this nurse had the luxury of establishing rapport with her patients during teaching sessions that lasted several hours and were sometimes spread over several days. This nurse participated in two observational sessions as she worked with a pair of middle-aged sisters who came to the hospital from their northern reserve community to learn how to manage one of the sister’s disease conditions. Although the nurse had the luxury of time, I would argue that it was not only the time spent with the sisters, but her interpersonal mannerisms that set the tone of these interactions.
Consistent with the philosophy she expressed above, her approach was relatively informal: jokes were exchanged, laughter was frequent, and social conversations about the sisters’ daily lives in a remote reserve community were interspersed throughout their teaching sessions. In interviews later, both sisters and the nurse remarked on the ease with which they each related to each other and the interpersonal comfort that was quickly established. From my interpretive vantage point, each described how their expectations of each other were exceeded. When the sisters returned to the hospital several weeks later, I accompanied them as they sought out this nurse (even though the nurse had switched units) “just to say hi.”

Even though pressed for time, nuances conveyed during interactions can signal an interest in connecting with patients. The following field notes recorded an interaction as the second nurse woke up R, an elderly First Nations woman:

The nurse had to wake up R for her a.m. meds, and for breakfast. She did this by bending over R, tapping her very gently on her back, and speaking gently, slowly. She remained close to R, leaning toward her, waiting for R to open her eyes before saying, “Sorry to wake you up but I’ve brought your medications.” R lifted her head from the pillow, opened her eyes for a moment, and immediately crossed her chest, bowed her head slightly, closed her eyes, and I got the sense that she made a momentary prayer. The nurse, seeing her movements, asked in a concerned tone, “are you okay? Are you very tired”? Softly but clearly, R responded, “Yes, I’m just praying,” smiling slightly, in a very soft voice. I remember thinking, if I had to be woken up, I would want the nurse to use this approach – the soft tone of voice, the slow movements, the gentle tap on the back. Later in the morning, the nurse came in to do a very brief assessment – to check for pedal edema and auscultate R’s lungs.
Again, her tone of voice was gentle as clearly explained to R, facing R, speaking directly to her, “I’d like to check your feet and lungs for a moment, then you can lie down again.” As she quickly conducted her assessment, she reported to R, “things are looking very good, R.” She waited for R to reposition herself in the bed and adjusted her blankets. She asked if there was anything R needed, then went away. This took all of two minutes yet there was no sense of rushing or scrambling to get things done.

[Field note entry].

From my interpretive perspective, the nurse’s actions conveyed a genuine sense of concern and caring. During the same observational session, I happened to be present as a First Nations LPN, woke up another patient in the same room. My reading of her actions was entirely different:

A different nurse [a First Nations LPN] came in swiftly to stand at the bedside of an elderly Euro-Canadian woman who was lying on her back with her eyes closed. The LPN, standing straight up, reached her arm over to the patient’s shoulder area, and tapped a pen firmly 2-3 times against the woman’s shoulder, looked down toward the patient, and at the same time said in a loud, voice – “how much of your fluids from your tray did you drink Mrs. [name]?–” The patient opened her eyes immediately, looked startled for a moment, and quickly provided a brief response. As I watched I found myself contrasting this manner of waking a patient with R’s nurse [above].

[Field note entry].

From my vantage point, the latter was depersonalizing whereas the former was connecting.

As I pondered these two observations, I began to question my interpretations. How might I have read the second interaction if the LPN was Euro-Canadian and the patient was First
Nations? Would I have read this as an example of Othering? Was I glimpsing the culture of nursing within a health care system where patients in general are Othered and depersonalized? Perhaps these two observations, read side by side, tell us that Othering can occur in any context when the Other is seen as different. I do not presume to formulate definitive responses – nor may this be possible. This line of questioning, however, is important from an analytic point of view, and highlights the need for a tentativeness in our interpretations as we attempt to unravel the complexities of health care encounters.

Although it is difficult to hypothesize why some nurses established relational rapport when others did not, the point I wish to raise here is that actions conveying respect and caring do not necessarily require greater time, skill or training in cross-cultural communication. Rather, as Reimer Kirkham (2000) has argued, “efforts at connecting [with patients] are rather elementary in a sense, as though they reflect the core of interpersonal relationships, namely respect....It seems, then, that seeking points of connection is a foundational strategy that precedes all other aspects of interpersonal care” (p. 175, 176-177). We assume that nurses will easily and naturally seek interpersonal connections. While the findings presented in this chapter suggest otherwise, patterns of social distancing are not deliberate or punitive; rather, they arise from long-standing, shifting and reemerging relations of power. Reflecting critically on these shifting contexts, therefore, seems essential to foster critical awareness of our role in shaping postcolonial health care relations.

Summary

The arguments put forward in this chapter have illustrated the ways in which assumptions about Aboriginal peoples, culture and difference constrain the relational aspects of nurses’ work with First Nations women. The cultural model, intended to sensitize nurses
to differences, does not extend to a critical analysis of historical relations, or how these shape routine interactions. Popularized images and discourses about Aboriginality, culturalist assumptions, and past experiences shape the ways nurses view and react to First Nations patients. The relative lack of informal social dialogue between most nurses and First Nations women represent markers of social distance. Despite this overall trend, some nurses interacted differently, easily establishing points of connection by conveying a sincere interest in their patients. However, without a greater understanding of the significance of power differentials, history, and positionality, social distances continue to be maintained, not surmounted.

Another layer of complexity becomes apparent when viewed from the patients’ perspectives. As illustrated in the following chapter, First Nations women apply an entirely distinct analytical perspective as they discuss their health care experiences and interactions with nurses.
CHAPTER SEVEN

THE PRAGMATISM OF FIRST NATIONS WOMEN

Introduction

In this chapter, the focus shifts to consider First Nations women’s accounts of their interactions with nurses and their overall hospital experiences. During informal conversations with women while they were in hospital, and later, during more in-depth discussions in their homes, women described their experiences, their views of nurses, and the ways in which their personal circumstances organized experiences within and outside of the hospital. As might be expected, women and nurses held very disparate views of their interactions with one another. This is not surprising: women and nurses speak from vastly different positions of power and privilege. Informed by postcolonial perspectives, the goal of this analysis is to explicate the contexts in which women construct their accounts, and how gender, ‘race’, class and historical positioning intersect to organize health care experiences.

Whereas nurses tended to frame their perceptions of First Nations women in objectifying terms, the women who were their patients framed their accounts around one predominant theme: “all the nurses are good.” Rather than questioning, challenging or critiquing the culture of health care (as women in previous studies had done), women turned their analytical gaze inward to consider how they were perceived by health professionals and how they could best fit into the existing dynamics and routines. In most instances, the pragmatics of fitting in meant waiting patiently, accepting delays in hospital routines and placing few if any demands on the nurses.

Using a series of vignettes, I show how a complex interweaving of social positioning, material circumstances, and past experiences shapes women’s interpretive lenses, their
relations with nurses, and the strategies used to navigate the health system. The vignettes presented have been selected because they illustrate issues that are germane to other women in this study. Although the life circumstances of the women differed in several respects, the vignettes highlight the range of socially mediated processes that shape women’s views of nurses, their hospitalization, and other aspects of the health care system. In developing my analysis and interpretation, I move beyond describing women’s experiences to illustrate how these are influenced by wider social relations extending well beyond communication difficulties or cultural differences.

The chapter begins with an analysis of the complex factors and contexts that shape women’s constructions of their health care experiences, including the dynamics of researcher-participant power relations. Deliberately positioned at the beginning of the chapter, this subsection aims to make my interpretive analysis transparent as the women’s narratives are discussed. I present an analysis of women’s perceptions of their encounters with nurses using selected vignettes to contextualize women’s interpretations. Beginning from the standpoint of women, I examine what is implied when they report that all the nurses are good. I then turn to an analysis of how women’s vulnerability as patients and as research participants might have influenced the stories that women chose to discuss with me, and the subtexts embedded therein. The final section examines the range of strategies that women use to navigate their relations with nurses.

The Complexities of Framing Health Care Experiences

Women’s accounts of their current in-patient experiences at the hospital were constructed very differently from their experiences seeking services in emergency departments, rural hospitals, or at community-based walk-in clinics or physicians’ offices.
Any concerns or criticisms raised about health care were exclusively framed in reference to those community-level services. When discussing their present hospitalization, however, women were unfaltering in their praise of nurses and their overall in-patient experience.

The consistency of women’s responses, captured in the phrase, “all the nurses are good,” contrasts with other research describing significant concerns about community-level health care (Frideres, 2002; Royal Commission on Aboriginal Peoples, 1996b). In Chapter Two, for example, I reviewed research conducted with women in the same geographic area who were painfully aware of how doctors and nurses in community-based settings reacted to them as First Nations persons (Browne, et al., 2000; Browne & Fiske, 2001). Similarly, studies in other regions of Canada document how attuned patients can be to power differentials and negative attitudes (Baker & Daigle, 2000; Browne, 1995, 1997; O’Neil, 1989, Sherley-Spiers, 1989). Why then were women in this study seemingly uncritical of hospital-based health care?

I am not suggesting that women ought to have viewed their nurses in a more critical light or that women’s accounts are somehow invalid. Nor is my intent to discredit their perspectives. Rather, my aim is to unpack women’s accounts of their interactions and experiences, and in the process, think critically about what was and was not said. Taking this as my starting point, I give consideration to the complexities that underpin patients’ interpretations of their hospital experiences.

To some extent, the uniformity of women’s accounts may reflect a popularized cultural script which constructs nurses as virtuous professionals who can do no wrong. To patients in hospitals – who must rely on health professionals to ensure their survival – it may
be unfathomable or counter-productive to think that nurses might hold particular biases. While these issues may be at play, it is also important to push the analysis further.

Careful attention to the social and historical positioning of the researcher and research participant is paramount to inquiry conducted from a postcolonial perspective. As Alison Jaggar (2000) writes, “we must never forget that empirical discussions are always infused with power, which influences who is able to participate and who is excluded, who speaks and who listens, whose remarks are heard and whose dismissed, which topics are addressed and which are not, what is questioned and what is taken for granted, even whether a discussion takes place at all” (p. 5). Considering my own position of power and privilege prompted me to ask, how could women be candid about their care to someone who is perceived to be an agent of the institution? Critiquing the system carries a certain risk. Patients might alienate the nurses; their vulnerability at a critical time could be potentially intensified. These are very legitimate reasons not to voice dissatisfaction. In the words of one woman, “I do not put down nurses!”

Whereas my role in previous research endeavours (e.g., Browne, 1995; 1997; Browne et al., 2000; Browne & Fiske, 2001) came with a certain insider status (that is, I was known to the community), in this study, I was unknown to the participants. Without a context in which to locate my role, my status was as an insider to the system: I was, after all, a nurse-researcher-professor. This has prompted me to consider how women may have constructed accounts of their experiences for me as a White, (seemingly) high-ranking nurse.

There are numerous complexities at play as patients frame their health care experiences for varying purposes and in varying ways. LaRocque (1993) urges us to consider how the process of internalization weighs into the analysis. The notion of internalization
directs us to consider the extent to which peoples' expectations are influenced by historical relations of authority, paternalism and subordination. Drawing on Adams' (1975) work on the destructive processes of colonization, LaRocque defines internalization as a process of "believing – or swallowing the standards, judgments, expectations and portrayals of the dominant white world" (p. 74). LaRocque acknowledges that this concept is somewhat dated given Aboriginal peoples' growing awareness of the wider sociopolitical issues influencing their position in Canadian society. She argues, however, that internalization continues to have relevance in the current context, writing, "the damage has been extensive, and the problem of internalization does still exist" (p. 75). For LaRoque, there is still value in considering the processes of internalization: "Understanding of the complex workings of the internalization process may be the key to the beginnings of understanding the behaviour of the oppressed and the oppressive in our communities" (p. 74).

Women are often the gatekeepers to the health care system for their families and communities, either as mothers and daughters, community health representatives, or as non-professional staff members working in health care settings. Positioned as subjects within long-standing relations of power and domination, some women may come to view dismissive attitudes, social distancing, and other forms of marginalizing practices – conveyed to them or their family/community members – as normal. Accepting and perhaps anticipating these patterns of relating as standard erases them as incidents that should be questioned or problematized.

Understanding how internalized expectations may be at play reminds us to consider the extent to which subordinated subjects can see or conceptualize the dominant practices which have come to be expected as normal (Jaggar, 2000). This is not to suggest that women
are cultural dupes or exist in a state of false consciousness\(^\text{59}\). The purpose is not to diminish the significance of women's perspectives that all the nurses are good. Rather, I wish to remain conscious of the power dynamics and subject positionings that inevitably shape women's experiences and their accounts of those experiences. Paying attention to these complexities without objectifying women's experiences will help us to think critically as women's accounts are read and interpreted.

**Women's Perspectives: "All the Nurses are Good"**

Presenting women's perspectives requires the reader to have some sense of the contexts in which they arise. The vignettes that follow help to illustrate how women's personal, social and material circumstances provide a backdrop against which they concluded, "all the nurses are good."

**Vignette: Ms. Z**

Z is the woman involved in the phone incident described in Chapter 6. Like the other women in this study, Z was emphatic that "all the nurses were good." To provide a context for understanding what "good" can imply, I give consideration to Z's personal circumstances.

Z, who is unemployed, has difficulty making ends meet. She changes residences frequently and currently shares her rented suite, which she describes as a "dirty mess", with her adult daughter who is also alcoholic (according to Z) and disabled. To supplement her meagre social assistance payments, Z rents rooms in her apartment to male boarders who "just go out, have a drink, come home." Z has difficulty supplying groceries for the

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\(^{59}\) Elsewhere I have pointed to the problems inherent to the notion of false consciousness, particularly as it has been used in critical social theories. These concerns stem from what is implied by false consciousness. Most significant to my argument is that, in a practice context, false consciousness has the potential to undermine "epistemological assumptions about who can contribute knowledge and what counts as legitimate knowledge" (Browne, 2000, p. 48).
household because "they [groceries] would go missing the next day. If I bring groceries home, that's it, they disappear. So I just don't bother any more. It's not worth it." Taking in boarders also means that Z is in breach of social assistance regulations, which restrict her from accepting any additional income. As a consequence, portions of her social assistance payments are periodically withheld, and she is routinely chastised by her social worker for "abusing it [the system]."

Although both Z's nurse and I viewed the phone incident as representative of unwarranted differential treatment, Z does not necessarily concur. In reference to her current hospitalization, and thinking back on her frequent visits to the hospital's emergency department, Z stressed to me that "not once" was there ever a time "where things didn't go so well with the nurses or doctors." Rather, Z described how grateful she felt toward the nurses and aides involved in her care. For example, on her first night in hospital, Z experienced high fevers and delirium. Although she cannot recall the exact circumstances, she described her sense of being well cared for by the nurses (who were actually nurse's aides):

Z: Everybody just comes together to try to heal me. Like when I was really, my temperature was way up, I don't remember any of them coming here. I woke up in the morning, and the girl took my temperature and said "we did it." I said, "did what [laughter]?" I thought I was just sleeping from 7:00 in the evening to 7:00 in the morning. "No, no, no, no, your temperature was way up." [S]he said "we had to pat you down with warm water and stuff like that, roll you over", I said "you did?" [S]he said "yah, we took your temperature every half hour." So I said "wow." I said "I don't remember that."... That wasn't the only night, the second night, the same

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60 Many Aboriginal languages do not have a gendered pronoun. It is therefore common practice among First Nations and other Aboriginal groups to use "he," "his," and "him" generically and also to use such words as "guy" for both female and male persons (J. Fiske, personal communication, January 20, 2003).
thing. My temperature was right up again. And they did the same thing only it was a
different team. And, and umm after that, it just went down. I felt better again. Now
they don’t come around anymore. [laughter]. Where are they when you want them to
come around [laughing, joking tone]!

Z has not always lived a marginal existence: in the past, she has worked for First
Nations organizations and social service agencies, and is a politically informed woman. For
example, she was well aware of the nursing shortages and crises in health care so frequently
depicted in the media and popular press around the time of her hospitalization. These
messages about the health care system shape patients’ expectations of what they might
encounter once admitted. Z, for example, explains her sense of surprise at receiving what she
interprets as high quality care:

Z: Oh yah, they say hospital care has deteriorated because of lack of nurses and stuff
like that. Look what happens when I come in! Maybe I am only one person but when
I come in I get the best care possible. So I am contradicting what they are telling.
Okay, there are not enough doctors, but there are doctors around and they do come
around. It takes a little time [before they come around] but there are lots of nurses to
look after you.

In actuality, my observational data indicated that direct contact between Z and any nurse was
minimal; Z’s nurse confirmed my perception. Had Z completed a patient satisfaction survey,
for example, her responses might be interpreted as quite straightforward: she is clear about
the level of satisfaction she perceives. I suggest that such an interpretation is incomplete;
rather, there are a number of intersecting factors to consider as we attempt to situate Z’s
responses in a wider social context. One of these relates to Z’s current social circumstances.
As an indigent woman, Z may indeed feel genuinely grateful for the care and attention of the nurses and for regular meals. As Z describes of her ex-partner who still "comes around to visit when nobody else will," the interest conveyed by nurses and aides who "come around to check" on her may carry particular significance as gestures of kindness. In hospital, Z is temporarily transformed from someone whom authority figures (i.e., her social worker) perceive as abusing the system to someone with legitimate needs for health care. Other angles of analysis, however, must also be considered. Z's interpretation may have been framed as such for me, as an authority figure. To do otherwise – to express criticism – might place her in a more vulnerable position. Under these circumstances, it is understandable that Z might keep her critical gaze in check.

Consideration must also be given to my postcolonial reading of oppressive practices in situations where participants may view it otherwise. My interpretation of the phone incident, for example, focused on the racialized and gendered relations that were played out during a routine nurse-patient interaction. When I suggested to Z that some women may feel that their identities as First Nations women affect their care, she responded with irritation stating, "this is a pile of rubbish!" Herein lays a significant methodological and theoretical issue. How do we as researchers make sense of inherent contradictions in acknowledging women's subjective analyses "while at the same time holding an explicitly political vision of the structural conditions that lead to particular social behaviors, especially when such political insights are not shared by research participants" (Reimer Kirkham & Anderson, 2002, p. 10)?

During one of my clinical shifts in the emergency department (i.e., a non-research shift), Z brought her ill daughter into emergency. While there, she requested a meal for herself and her daughter as they waited for treatment. The nursing staff who seemed to know Z as a semi-regular patient in the emergency department quickly ordered the meal trays, recognizing that Z and her daughter may well have been hungry and in need of a meal.
Lather (1991) has identified this question as a paradox inherent to praxis-oriented research. As she writes, how can researchers “maximize self as mediator between people's self-understandings and the need for ideology critique and transformative social action without becoming impositional” (Lather, 1991, p. 64)? One solution is to reflexively reexamine the dialectic between theory, women's perceptions and my interpretations. Another is to maintain a degree of tentativeness in interpretations, particularly as we reflect on who holds the dominant voice in nursing practice and scholarship (Reimer Kirkham & Anderson, 2002). Neither of these angles of analysis is undertaken to discredit women's perspectives; rather, the aim is to unveil the complexities inherent in reporting and learning from women's accounts of their experiences.

**Vignette: Mrs. Y**

Y's circumstances, while very different from Z's, also help to highlight the importance of locating health care experiences within their wider social/material context. Y is a 60-year-old woman who lives on social assistance. According to Y, much of her energy is spent coping with chronic pain from two deteriorating health conditions. As Y discusses the challenges of managing her chronic pain, she emphasizes the difficulties she faces in obtaining relief from the allotment of Tylenol #3 prescribed by her doctor each month:

Y: When I run out of medication and I have got that pain, I have to buy my pills sometimes on the street for medication because I run out and I can't see my doctor and this is what a lot of people are doing.

A: They are selling some Tylenol #3?

Y: They are selling everything. Yah. It is sad.

A: And you are sure you are getting the right medication when you buy it like that?
Y: It is just a chance, you know. It is sad. It is very hard for some people like I said. Very poor people and this is the way it is set up I guess.

She expands on her understanding of why she is not prescribed adequate amounts of Tylenol #3 by her physician:

Y: Yah he is prescribing them but I have to wait a certain time, he prescribes only at a certain time because he doesn’t want to over prescribe because the government doesn’t allow that but I can’t see why the government doesn’t allow it if it is a certain case where a person is in lots of pain. I mean how do you, who is the judge of that except the patient?

A: So you run out of them and you have to wait to get them filled again?

Y: Yah. Yah the endless pain and the endless struggle each month and the endless having to look for some to buy from somebody [on the street] and the supply is so great downtown that they are just all over. The patients really need them. Just can’t afford it.

A: So you have to rely on buying them somehow on the street every now and again?

Y: Yup. Yup and not just me, other people too. Lots of people, I know some old ladies in the same situation.

Y is referring to the limitations placed by the First Nations and Inuit Health Branch (the federal department responsible for financing and regulating prescription drugs and other non-insured health benefits for status First Nations) on the numbers of Tylenol #3 prescriptions that can be issued to status First Nations patients. This drug policy stems from recent concerns about the exceedingly high rates of Tylenol #3 prescriptions filled by First
Nations patients\textsuperscript{62} (Health Canada, 1999). Y, who has become caught in this ostensibly protective policy, procures pain medications at great risk to herself. When she was admitted to hospital for an exacerbation of her chronic disease conditions, she was immensely grateful for the medication which provided her with pain relief:

Y: And they had the pain medication where I could handle it. What they give me in my IV, I don’t know but they had it where it wasn’t hurting that much in my leg and I was able to walk. And then when it got stiff, I would walk around a bit.

Y’s hospitalization also coincided with the anniversary of her husband’s death by homicide eight years ago. As she explained to me:

Y: Tragic things that have happened in my life and I live with this. I don’t know if I should mention that my husband was murdered and this affects my mind and my health to some extent each fall like. And it just seems to worsen these conditions in my lungs and my bones really.

Adding to the stress that culminated in her hospitalization, one week prior to her admission, Y’s 40-year-old nephew was admitted for palliative care and died soon after on the same unit to which Y was admitted. Her account of her own hospitalization is intermingled with her recollections of how her nephew was treated:

Y: They really took good care of me there. The lab and all the lab work and all the people that I talked to that are there, the people with the Ventolin to put in the mask. They were really, really good. They put lights on for me at night. They knew I was kind of agitated and the people on night shift would come and check on me. I just found it so comforting to be there. I really appreciated their help....They are really

\textsuperscript{62} In 1996, for example, the First Nations and Inuit Health Branch reported that Tylenol #3 prescription rates (991 prescriptions per 1,000 people) in the Western provinces were almost 4 times higher than rates in the Canadian population (Health Canada, 1999).
quite attentive to their patients. When you need something they are right there. You don’t wait long. They just come right now. They are very good. I wished there were more nurses. They got quite a job to do but they are very good because when my nephew passed away there, the nurses were so nice to my family. They explained everything as the process of his passing away was. They explained it to all of us and they held on to us and they were very sympathetic. That floor, I really appreciate what they had done for me. They were really nice people. There were no problems there. My kids told me I wouldn’t want to come home. [Laughs briefly]. They said I got treated like a queen there. With the food and everything, I liked the food and everything was good....And yah, each morning for coffee....I had all my books. Yah it was good.

For Y, hospitalization brought pain relief, the opportunity to rest, and a sense of feeling cared for during a very stressful time. The care extended to her nephew’s family also shaped her overall sense of appreciation; these circumstances influenced her reading of her hospitalization.

From my interpretive vantage point - as the third party observer - what is made visible and conversely, what is hidden during the provision of health care is revealing. For example, Y’s reading of the good care provided to the family of her dying nephew stood in contrast to behind-the-scenes comments overheard by a First Nations nurse who worked on the unit. Independent of knowing that Y was the aunt of the man who passed away, this nurse described her colleagues’ reactions to the family visitors:

RN: I know the one Native guy that passed away. Hardly anybody came to see him, he was really sick, and like when he passed away all his relatives came to pay
respects, and that is just part of the culture but the other nurses were complaining about that. They are “oh, look at all these people, they didn’t even come see him when he was alive” and like they were really disgusted with that. But I wasn’t and I was like “maybe he didn’t want them or maybe they didn’t want to see him like that.” But when someone passes away, you have to go and pay your respects and at least have support for the mom or the sister, or whoever is grieving the most. You know that is why they all came...And Native people take note of who comes to pay their respects. They remember “oh yah you came and I am so thankful for that.” And that is just how it is.

A: Yah. And did the nurses accommodate the family that was coming in to see this man?

RN: Yah they were okay, but again behind closed doors they were complaining.

“Look at all these people and where were they when he was so sick.”

The point in comparing Y’s and the nurses’ perspectives is not to set one in opposition to the other. Rather, exposing both perspectives illustrates how complex it is to read health care interactions. From the nurse’s viewpoint, disparaging comments about the family represented evidence of the ways in which nurses can judge First Nations people. These attitudes may well have been appropriately contained behind closed doors. Alternatively, Y may have chosen not to discuss these issues with me because of my insider status. The intent here is not to figure out whether good care was (or can be) provided in the face of seemingly negative attitudes towards the family members; rather, I wish to emphasize the complexities inherent in analyzing health care interactions. What may be read as good or as culturally safe by one person may not be read as such by another. Remaining cognizant of these complexities is
valuable, not only in research contexts, but in the practice arena as nurses reevaluate the ease with which seemingly obvious interpretations can be drawn about the Other during health care interactions.

What Can Be Disclosed?

Meleis and Im (1999) argue that competent scholarship about marginalized populations must include attention to identity, power differentials and issues related to disclosure. Following their lead, I give consideration to the stories that women chose to discuss with me, and what they did not. The intent is not to identify gaps in their accounts, but rather, to highlight their perspectives as windows into wider social processes. For example, although women constructed their hospital experiences very positively, stories told about incidents outside the hospital – at rural hospitals, the emergency department or physician’s offices – revealed their acute awareness of the potential for health care providers to react to them negatively as First Nations women. Understandably, it is seemingly safer to discuss serious concerns about health care in relation to other health care settings. However, the silence surrounding these concerns in relation to the hospital does not mean that it is in some way immune to these issues; my observations indicated otherwise. Rather, it may be more productive to view women’s perceptions of discrimination in these other settings as windows into the workings of the health care system at large.

Several women were clearly comfortable discussing care they felt was discriminatory or racist. As Y asserts below, “we [Y and her granddaughter] wanted you to know [about our experiences with discrimination].” Although consistently framed as occurring outside of the

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63 Although the emergency department is physically connected to the hospital, the women interviewed spoke about it as an extension of the primary care system – as their first point of contact with the health care system, at which time their concerns were evaluated as legitimate or not. It is therefore distinguished from the hospital’s in-patient units (where data were collected).
hospital, these accounts are nonetheless reflective of everyday tensions encountered by women in the wider social world.

**Vignette: Ms. C**

C is a 25-year-old mother of two small children who lives in a reserve community adjacent to a small rural Euro-Canadian community. A large proportion of her conversation with me focused on acts of violence perpetrated toward family members, which she perceived as racially motivated. These experiences frame her reading of "racism" in a small rural hospital.

As our conversation proceeded, her own story of being mistreated in a small rural hospital became intertwined with stories of assault and murder within her family and social circle. For example, she spent considerable time reflecting on the circumstances of her uncle’s murder in a Euro-Canadian community adjacent to the reserve community, and became visibly upset as she described how local police “beat up” a cousin for no known reason. According to C, both incidents were instigated by “racist people” caught up in antagonist relations between Aboriginal and non-Aboriginal peoples within the surrounding communities.

C’s experiences with racism extend to the nearby rural hospital, where she initially sought treatment for acute abdominal pain. At the rural hospital she was kept under observation for four days, after which she was transported by ambulance to the city hospital, where she underwent immediate surgery to correct the abdominal problem. C believes that,

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64 C was one of several women who candidly discussed personal experiences with violence. Of the thirteen women in this study, seven described how their lives were profoundly influenced by violence. These are not isolated incidents; such stories reflect the collective concerns of many Aboriginal women’s organizations about the vulnerability of women and children to violence in their homes and communities (Royal Commission on Aboriginal Peoples, 1996c).
in the rural hospital, her illness was not taken seriously and as a result, that treatment was delayed. From her perspective, the nurses and doctors at the rural hospital did not provide prompt, appropriate treatment because they were “racist.” When asked to explain what this meant to her, she described how they “laughed at me” and “didn’t take me seriously that I was in pain,” and how her “Auntie had to get mad at the doctors and nurses” in order to advocate on her behalf. C’s suspicions about the inappropriate care she received were confirmed when at the hospital, doctors and nurses immediately rushed her into surgery. She compares her distressing experiences at the rural hospital with the care received at the city hospital:

C: They don’t take nothing seriously in [name of rural town].
A: Sure didn’t make you feel very good.
C: No. Made me pretty low. It made me feel like they didn’t give a care. At least the nurses around here [in the city hospital] are nice. They show they care. They call you sweetie, darling, all that stuff. They make sure we get what we need. In [rural town], no, there’s at least one nurse that calls you sweetie and that, but the rest of them, I don’t know. They just give you dirty looks. Give you a hard time. Like what did I do to you guys, I never did nothing to you guys, why are you treating me this way?
A: So can I ask you, um, what is it that the nurses were doing that made you feel that they were racist? That they were treating you in a discriminatory way?
C: I feel they are racist. I don’t know. That is the way I feel because there is too much racism I see everywhere I go. And that is why I figure they are racist. Cause my uncle died because of racist people killed him…. Especially in [the rural community], it seems like Native against Whites. But, I don’t mind White people at all. I have
family member that are White, half White. But there are some racist people. I don’t like racists. I don’t mind the people, but I don’t like their, the way they act around Natives and that. They all think they are drunks, and they all lie. That’s the way I feel about those nurses, that they don’t believe us because they figure we’re lying. I wasn’t lying. I could have died because of them.

Distanced from the rural hospital, C discloses the sense of outrage she and her Aunt felt as their concerns about a genuine health condition were repeatedly dismissed. Her story illustrates how patients and families may feel forced to react with anger and desperation as they attempt to seek health care for real or perceived health concerns.

No longer required to “get mad” to receive health care at the city hospital, C’s interpretive perspective shifts. Whereas “sweetie” or “dearie” might signal patronizing or demeaning terminology, to C, these represent caring expressions. Although observational data presented in Chapter Six involving a nurse’s interaction with C as she removed her IV provided one of the clearest examples of distancing, like other women in this study, C reiterates that “all the nurses are good, they really care.” I was also aware of nurses’ comments made behind-the-scenes and in interviews, in which C was constructed as an irresponsible mother and as drug seeking. While these kinds of attitudes may have fueled the “dirty looks” and comments that C was attuned to at the rural hospital, no mention is made of these behaviours at the city hospital. Suspicions so vehemently expressed in relation to the rural hospital do not figure into C’s discussions about the city hospital. This cannot be interpreted as naive contentment with services at the city hospital; rather, a more nuanced analysis must consider the extent to which patients feel safe (or not) at the time accounts are constructed.
Mrs. Y

Like the other women in this study, Y described how satisfied she was with the care provided to her as an in-patient. During our conversations, however, Y also spent considerable time discussing how her identity as a First Nations woman shaped her experiences with health care. These too were framed as hardships encountered outside the hospital. For example, Y explained the source of her difficulties obtaining analgesics:

Y: Yes, my granddaughter told me to tell you. Grandma, she said “you tell [the researcher] if you had White skin and White hair, would they give you the pain medication that you really need? They would give you enough”, she said, “instead of giving you such a hard time every month that we see you going through at the hospital and at the pharmacy sometimes”. You can tell there is discrimination there.

The sense of vulnerability Y feels as a First Nations woman is reflected in her understanding of how she is treated when she seeks health care (frequently) at the hospital’s emergency department:

Y: One time I sat at emergency, well I sat there it must have been two hours I think and this doctor came out and he had seen everybody. I went there for my leg again. I waited and waited and I was the last one there. I could see him on the other side. He wasn’t doing nothing. He was just at the desk. I just couldn’t sit there no more. He forgot me. He forgot me he said. So I told the nurse I said I am angry because I am just too dark. I can’t wait for that. I am in pain and I can’t wait for him no more. But he took everybody else. There was discrimination there too.
These experiences fuel Y’s perception that she is made to wait because “they assume this and that… and sometimes they just ignore you.” She is sensitive to how health professionals view her when she presents at the emergency department for control of her chronic pain:

Y: I don’t want to abuse medication to that point. I use the medication for the pain to relieve, to help me to walk, to do my work, to be able to function as a person, but sometimes these pharmacists, doctors, nurses, hospitals – like “you are overdoing it.” “You are overtaking it, you are taking way too much” and it makes me feel like I am some junkie and I don’t know my pain level.

Y’s suspicions about how she is viewed by some health professionals are confirmed when her granddaughter – a young mother – is questioned about possible child abuse. During an observational session, both Y and her granddaughter spoke with me at length and expressed great concern about this incident, which occurred when the granddaughter took her two-year-old son to a walk-in clinic to have a lesion examined. Y described her reaction and outrage:

Y: Yah because my granddaughter’s a little bit dark. Right away they [the doctors] are saying children are being abused and everything. And that little boy has been taken such good care of… He [doctor] still wants to see if they [the sores] are healed so we go again. But for a while there, I saw the Native court worker and she said if there was any more discrimination that we would have a lawyer look into it because my granddaughter is part Native and there has been some, we could tell, could sense that there was something like that there. It isn’t right. But he is a tough guy.

A: Who the doctor?

Y: Yah.

A: Is that who you meant?
Y: Yah. Yah. Yah. But I faced him [voice is soft]. It was my privilege, I faced that man. Like I said I have been around for years and it takes somebody tougher than that to shake me up.

In addition to outrage, Y speaks with resignation as she acknowledges a lifetime of dealing with discrimination:

Y: I don’t like thinking about discrimination because people are people in my opinion, but there is, and it is a world we live in. But personally I don’t like it. It doesn’t really bother me. I am so used to it. It doesn’t hurt me that much, like it used to when I was a child growing up. It doesn’t hurt me that much. I have learned to deal with it. I just wish there was a little more help for Native people that they would help them a little more and understand them that they do have pain and they do know what is wrong with their bodies and when they go somewhere, they do want a little help that is all and they appreciate that. You know.

Acutely aware of how racialized and gendered stereotypes can influence the health care she or her family receives, it is understandable that, in hospital, Y is pleased to obtain reprieve from the stress she experiences elsewhere. At the same time, portraying the in-patient setting as untainted by processes happening in other areas of health care and in the wider social world, suggests the formation of boundaries drawn (perhaps unconsciously) around that which can be disclosed, and that which may be better left unsaid.

Ms. N

N is a 42-year-old woman who moved to the city from a reserve community to complete a university degree. Admitted for elective surgery, N described how anxious she was about her admission, and how surprised she was to learn that “it wasn’t so bad.” The
story N disclosed to me was traumatic and emotional, and related to an experience she had in a rural hospital as young woman. In part, she drew on this formative experience from her past to contextualize the fear she experienced in anticipation of her current admission, and why (to her surprise) her expectations were exceeded. N’s story was also positioned within a larger conversation in which N considered how her identity as a First Nations woman influenced her interactions in the wider social world. I include excerpts here to illustrate how experiences from the past – which are perhaps safer to discuss than experiences in the present – shape future expectations.

As an 18-year-old woman, N was admitted for management of premature labour to a rural hospital located in a predominately Euro-Canadian town near the reserve. Her baby died soon after the delivery. She described how desperate and alone she felt, and how “they just left me there. I hated hospitals. I hated doctors. I hated nurses. I hated everybody.” She went on to explain the events that followed:

N: It just felt like they just didn’t care and I don’t think we… Actually they told us the next day, the doctor comes and he says, well we need to send the baby off to the city for an autopsy. “Okay.” He says “but it is a lot cheaper if you took him down there.” We are, like, “okay.” So I got ready, they let me out of the hospital that day. They put him [the baby] in a little cardboard box taped up on both ends, put him in the trunk of the car. We drove here to [city] [a five hours drive], brought him in, dropped him off where they told us to drop him off. They did an autopsy and then we drove him back like that. We did lots for the [rural hospital]. That was the worst experience of my life. I was what, 18 or 19?
As she moved through this story, N proceeded to discuss her experiences raising children in a reserve community adjacent to a rural town, where racialized tensions were common-place. One story led into another. For example, she discussed her current experiences at university as the racially-marked other who was grouped together with other First Nations students in the class and inevitably assigned the “First Nations projects” despite their interest in pursuing other topics. Embedded in these stories were glimpses of N’s sense of personal agency and convictions about transforming unequal power relations. For example, in response to repeated racial slurs directed toward her daughter at the local school, N described how she and another parent worked with teachers to develop a curriculum to address the local history of First Nations people in the area. N’s sense of personal agency also carries over into the health care arena. As N describes, she is able to “get what I need,” “just the way I am, like I voice my opinion or if I need something I ask for it and whatever.” The trauma she experienced in the past stands in sharp contrast to the control she exerts over her current hospitalization.

The issues raised by N, Y and C, framed as incidents occurring outside the hospital, are nonetheless revealing as factors shaping women’s experiences of health care. Different stories would likely have been disclosed to a First Nations interviewer; this is a limitation of the study, which, I suggest, does not detract from their relevance. Rather, the perspectives that women shared provide an opportunity to give voice to previously subjugated voices, and to think critically about the processes and practices that structure women’s experiences.

**Navigating the Hospital: “Getting Along with the Nurses”**

Contrary to nurses’ constructions of women as passive players in health care interactions, observational and interview data revealed that women were active in their
efforts to “get along” with their nurses. Well aware of their potential to be viewed in stereotypically negative ways, responsibility for getting along rested firmly on their shoulders. Focusing on how they related to nurses, women emphasized the importance of getting on “the nurses’ good side.” As the following vignettes illustrate, these strategies help women to navigate their relationships and position themselves as good patients.

**Vignette: Ms. G**

G’s discussion is drawn on as a case in point because her argument is so explicit. At age 68, G has had a many hospitalizations over the course of her life. Her first major hospitalization was at age fourteen when she was admitted for treatment of TB in a hospital located eight hours from her reserve community: she remained there for five consecutive years. Upon returning to her home community, she was wed through an arranged marriage to a man who G described as “a drunk.” Although G left this marriage many years ago, she made reference to how “awful” it was and how often she found herself “in and out of hospital” during this relationship. Over the past decade, G has had at least ten hospitalizations for various major illness episodes, which have contributed to her extensive experiences with health care.

As with other participants, G discussed her most recent hospital experience in terms of the excellent nursing care she received:

A: Maybe just tell me what stands out for you most about your hospital stay and how things went.

G: Well. Everybody treated me real nice, like nurses, they know everybody, friends like, you know. They always take good care of me. Yah, it was good.

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65 Catholic priests and appointed church chiefs commonly arranged marriages within First Nations communities in the region, beginning in the mid-20th century and continuing less frequently but as recently as the 1960s (Fiske, 2000b).
A: And can you give me an example of how they were nice to you?

G: How they are nice to me? Well, they always come and check on me, and then they ask me how I feel, and [if anything is] wrong... Well they are all kind to me, and all that. They talk to me, and they explain everything to me, and I ask them questions.... Everything was good.

Again, it is difficult to determine the extent to which my own location shaped G’s interpretation (nor does the dissertation aim to make this determination). The content I wish to draw attention to, however, relates to the strategies she has learned over the years to get along with the nurses:

G: I get along with them [the nurses]. I get along with them pretty good.... I’m patient... That is how I am. I’ve always been like that. I’ve had so much experience staying in the hospital and that’s how I always am.”

In an interview with G’s nurse, it is apparent that she concurs: from her perspective, G was indeed a “good patient to take care of, she had a big surgery and she was a tough lady. She was always very pleasant and smiling. She was quite nice to deal with.” Although observational field notes noted that contact between G and her nurse was minimal, during a quick dressing change, G initiated a dialogue about her home situation. Field notes recorded my impression of how easily G seemed to traverse the social distance that seemed to exist with this nurse who from my perspective, was quite detached:

This nurse, when I met her, had what I would call a flat affect: very little facial expression, depressed-like, flat tone of voice, as if she is going through the routines in a business-like manner, but has nothing left to give in terms of smiling, raising her tone of voice.... Nevertheless, as her dressing was changed, G began conversing in
short phrases with the nurse about her home situation, as if G was continuing a conversation that had begun earlier. [Field note entry].

As G discussed her strategies for getting along, the focus shifted onto those First Nations women who do not make an attempt to get along. To illustrate her strategies for success, she compared her behaviour with others who behave very differently:

G: It's up to the person himself or herself. They have to clear all what they tell them, not get smart with them. I mean the person, like the other Native women. They have to obey everything that they say. But, I don't know, I don't know about this. They are not all like me [laughing softly]. Yuh. I know quite a few and they're rowdy... impatient. Ladies like that have to wait. And I don't say nothing. I just sit there and when they're ready they [nurses] come and get me.

Realizing – from experience – that her passivity is an asset, G is aware of the consequences that can accrue for women who act otherwise. Herein lays an important subtext. First, women who fail to listen, or who become impatient or “rowdy” place themselves at risk: in these cases, nurses may well be warranted in withholding or delaying care. Second, despite constructing nurses as “all good,” women are aware that nurses have the potential to treat women differently depending on their perceptions. Hence the need to maximize one’s potential to be seen as a good patient. G, who bears the burden of other women’s behaviours, must make efforts to distance herself from the angry Other.

Embedded in G’s advice to First Nations women is the need to get along regardless of the nurses’ disposition:

G: Me I don’t think that way. See, we’ve been with White people so long and we know which way, so I don’t think that way. I know they take care of the [Native]
patient the same way they do with the Whites and the others. At least for me. Because like how I said, they really took good care of me. Yuh. Yuh. I know that other Native women, they’re like that. Depends how they are, I guess.

A: Can you give me an example of how the other women are acting?

G: Let’s see. How can I put it….. I don’t know how I’ll explain it but, I know what they [other First Nations women] think. ...If a little bit, that the nurse is a little bit nervous or something is wrong, they think just because I’m an Indian that’s why you treat me like that. That’s what they always say around here and somewhere else. I listen to them. They said that is why they treat me bad. But me, I don’t think that way… I guess it depends how the Native women treat the other women – the other nurses. But me, I get treated good. Good as anybody else. Because, most of time, I’ve been in the hospital all my life, since I was 14.

The message is clear: First Nations women would do well to embrace responsibility for getting along with White people. To do otherwise or to claim differential treatment based on one’s identity would only detract from their positioning as a good patient. On the one hand, the principles which guide G’s navigational strategies can be interpreted as reflections of colonial relations of subordination and domination. On the other hand, a sense of resiliency and resistance underpin G’s ultimate strategy for surviving the system: “I get along with them [nurses] pretty good; I get along with all my enemies.” This too may represent a transformative strategy and an act of resistance (Battiste, 2000).
Vignette: Ms. Z

G’s views on how to manage her interactions with nurses, and the differential power relations therein, were echoed by other women in this study. Z (introduced earlier), also an experienced patient, reiterates the importance of getting along:

Z: I get along with everybody. If some people can’t get along with anybody, that is their own fault... You don’t just get respect, you have to earn it.... You have to learn to get along. It is up to you to get the best care possible for yourself. It is not who you know, it is here [patting herself on her upper chest]. It is yourself. I mean, if I was grouchy and all that you know, you think I’d have any care here? No. I would be too bitchy for that. And then I would wonder why they are not taking care of me.

Right? So there you go. I rest my case.

Implicit is the assumption that patients will automatically know how to get along. Those who do not, or who fail in these efforts, become the authors of their own misfortune. These edicts, based (perhaps unconsciously) on notions of rational individualism situate responsibility for securing good health care firmly with the patient. These ideas do not arise in a vacuum: they too reflect widely held, internalized, individualistic social values.

Vignette: Ms. N

N (introduced above), whose life experiences have influenced her capacity to negotiate power relations, counters dominant images of First Nations women as meek, unassertive or passive. Exercising her sense of personal agency, N describes how she mobilized her social skills to get along with a nurse who other patients found to be difficult. This nurse, who was “almost sergeant-like” according to N, had a palpable effect on the women who shared N’s hospital room; as N describes it, she made their “blood pressure go
up.” Despite the potential for intimidation, N explains how, “It was all right. I didn’t mind it at all. It wasn’t as scary as I thought it would be and, I know a couple of the other patients were like ‘oh, that nurse’...I learned to get along with her after all just excellently”:

A: And how was it to sort of get along with her [the nurse]? Like you said you sort of ended up getting along with her fine. How did that process develop where you learned to get along with her?

N: Because you can’t always look everything straight in the eye. I always try to look at it in different angles and say, you know, she is a human being. There is nothing, like I don’t fear her at all. I don’t. She is only doing her job the best way. Like, to me that’s the way I looked at it, so she was fine.

A: And I remember from watching her do the catheterization that afterwards you were sort of joking with her about it. And it seemed like in the end you kind of ended up, you know, getting along with her, joking with her and things like that.

N: Yah, it made it more fun. It makes it more fun for me to get along with people I guess.

In the end, N negotiated with her nurse to decrease the number of catheterizations she was due to receive. As N phrased it, she “won over” the nurse: “I mean, I probably could have talked her into lying for me [about the amount of her output and therefore, whether she would need the indwelling catheter].” Getting on the nurse’s “good side” represented a significant accomplishment for N, who was braced for a “scary” experience:

N: It was that turnover. Like, she did seem really powerful towards me but after a while I kept getting on her, I don’t know, my dad always said “once you get on their
good side, everything is okay”...So once we started to get along, I started feeling way better and more relaxed in there and it wasn’t so scary to be there.

N recognized that her capacity to maneuver her relationships with nurses would not come as easily to other First Nations women who “don’t want to say anything” and are “really intimidated.” This does not imply that women do not exercise other forms of personal agency to get along. From my observational perspective, exercising patience, avoiding use of the call bell, or making few if any requests of the nurses represented subtle but active efforts to get along. These too symbolize strategies for navigating and surviving a sometimes hostile system.

**Summary**

Examining health care encounters from the perspective of First Nations women focuses attention on the complexities inherent in nurse-patient and researcher-participant relationships, particularly when contextualized within historical relations of power and paternalism. This chapter has illustrated how interpretations of health care encounters are influenced by a complex intermixing of past experiences, social-historical positioning, internalized assumptions about how one should be treated, and portrayals of health care in the media. Aware of the potential to be viewed negatively by health providers, women interact with nurses in ways that position them as the good patient. Applying lessons learned through wider social experiences within and outside the health care system, women are pragmatic about the variety of strategies used to get along with nurses.

A particular methodological implication warrants mention, though a full discussion is beyond the scope of the dissertation. This relates to the current use of patient satisfaction surveys/questionnaires in quality assurance programs. Despite the uniformity of women’s
responses, that all the nurses were good, interpretations of health care experiences are highly contextual, and are mediated by complex social, structural, personal, and historical issues. Patient satisfaction questionnaires, based on the assumption that health care interactions involve neutral players and are inherently apolitical, tap into surface level information. This results in a fairly narrow understanding of how patients experience health care, and overlooks the complexities and contexts that influence patients' experiences, interpretations and expectations. Attention must therefore be focused on how more nuanced, contextualized, and rich information can be obtained. Such insights will be needed to shift long-standing relations of power in health care involving First Nations peoples.
CHAPTER EIGHT
NURSES' RACIALIZED WORK ENVIRONMENTS

Introduction

One of the central points made in this thesis is that health care settings must be understood as microcosms of the social world, not as neutral apolitical institutions. Anderson and Reimer Kirkham (1998) emphasize this line of argument, writing, "health care systems reflect the cultural values and the status of individuals within nations. As such, a health care system is a product of a country’s history and culture....[I]t is also instrumental in constructing nation by shaping identities and experiences, institutions and policies, oppressions and inequities” (p. 245). Sherwin (1992) has also argued that

Much of the explanation for the different ways in which health care providers respond to the needs of different social groups can be found in the very structures of the health care delivery system. The dominance structures that are pervasive throughout society are reproduced in the medical context...The organization of the health care system does not, however, merely mirror the power and privilege structures of the larger society; it also perpetuates them. (p. 228)

Examining varying forms of racialized discourses among nurses helps illustrate how issues of social location, cultural positioning, and identities are enacted in nurses’ work environments. These taken-for-granted discourses about Aboriginal identity and Aboriginal-state relations contribute to an environment characterized by racialized permissiveness in which dominant values and assumptions remain unchallenged and unquestioned. In this last chapter of findings, I examine the ways in which dominant discourses about Aboriginality are taken up
in the workplace and given expression in informal comments and conversations among nurses who are differently situated in terms of cultural and social positioning.

Racializing Discourses at the Workplace

Racialized comments were not only applied in relation to patients and visitors; First Nations nurses were also constructed as cultural, social and professional Others. As I illustrate, nurses’ workplace is itself racialized: comments about First Nations staff members are seamlessly interwoven with racialized comments about patients. At first glance, comments, jokes, and other seemingly trivial expressions of speech may seem innocuous. They are not; rather, as Reimer Kirkham argues, these discourses provide important “insight into the ways in which work settings may condone racism that is systemic and institutionalized” (p. 213).

I begin this analysis from the standpoint of First Nations nurses who, not unexpectedly, were more likely than their Euro-Canadian colleagues to see – and experience – racialization in practice. Although the political nature of these racializing practices may not be understood (or intended) as such by their perpetrators, they are immediately recognizable to First Nations nurses. For example, a newly hired First Nations nurse describes how her co-workers underestimated her professional ability when she first started at the hospital:

RN: Yah, I get a lot of comments saying “oh good for you. You are doing something good.” I am like “I am just doing something normal.” But I guess it is not normal, to them, to see a Native doing well.

Notions of Aboriginal peoples as benefiting financially from their special status are also generalized to their First Nations colleagues, as another nurse explains:

RN: So it comes up regularly, “Well you can afford it, everybody gets a free
education if they are First Nations". So it goes on from there and they talk about "well your health care is paid for." Well not all my health care is paid for. I still go and pay into the same policies that you do and they go "oh no, no, no." So the mentality is that. My thought is that if they had more education these comments wouldn’t be made.

As I continue to illustrate below, these are examples of the ways in which socially organized dominant discourses infiltrate the clinic and shape the routine dynamics of staff relations.

Essed (2002) argues that one of the features of everyday racism is that “practices with racist implications become in themselves familiar and repetitive”; in the process, “underlying racial and ethnic relations become actualized and reinforced through these routines or familiar practices in everyday situations” (p. 190). Nurses’ informal discussions among themselves – at the nurses’ station, medication rooms, staff lounges or cafeteria – represent a case in point. First Nations nurses and my own observations during field work confirmed the pervasiveness of “racist talk”, a term Essed (1991) uses to describe forms of racism expressed in casual conversations (p. 257). In this study, casual conversations among nurses included negative comments about First Nations people, specific patients, or First Nations staff members. Although these comments are often hurtful, First Nations nurses explained their colleagues’ comments as unintentional expressions of personal opinions. A 29-year-old First Nations nurse frames her colleagues’ comments:

LPN: Oh lots of comments, all the time, all the time. But I think some might be down-scaled a little bit when I am around. Because I have a big mouth, I don’t have a problem anymore, with standing up for myself, but again I work with great women. I really do, and yes, there are the comments, absolutely but they are from that stance
where it is not direct. They are not directly trying to hurt anybody. But maybe just in
their thoughtlessness, some remarks can be hurtful. I don’t think it is anything that is
purposeful.

The occurrence of racialized comments toward nurses of Colour working in other hospital
settings has been described by Reimer Kirkham (2000), who suggests that nurses make sense
of these experiences by reframing them in less threatening ways. This may help to explain
why First Nations nurses so frequently excused the attitudes expressed by their colleagues.
Essed (1991), however, frames these occurrences in another way. The racist comments per se
are not the primary issue; rather, it is the fact that they are exchanged in the presence of First
Nations nurses who represent minorities at the workplace. A First Nations explains how it
feels to be in the minority amidst racist talk:

LPN: I don’t take it personally but I have been, sitting, say, at the lunch table, where
the conversation has turned towards First Nations issues, and that is when a whole
bunch of the eyes [look toward me]. I don’t say anything, because you are not going
to change anybody’s mind over a 15 minute coffee break. You are just not. And I
have had nurses who know me come up to me afterwards and say “God, how did that
make you feel? Like they were really getting off on a tangent.” I can’t remember
specific instances but yah, there have been times when I have been sitting in a social
setting, not at work, you know like a break type setting. You are in the charting room
or whatever where conversations have been carried on that I find hurtful, that I find
offensive. You know, and again, I don’t think anybody is purposefully trying, you
know. They are just bringing up issues that they feel very passionately about, that
maybe just the way they are saying it.
Since these informal conversations are not aimed at specific individuals, they are not interpreted as direct racial comments; in turn, no counter response is anticipated (Essed, 1991). From my interpretive standpoint, however, framing these comments as merely thoughtless minimizes their political significance: they become located as individually-determined opinions rather than as wider ideological expressions.

Although First Nations nurses recognize the political significance of racist talk, those who had worked in the hospital over time (for years) overlooked these incidents to focus on more positive aspects of their colleagues’ practice. Even when her Euro-Canadian colleagues refused to orient a newly hired First Nations nurse, this more experienced First Nations nurse found it difficult to confront the underlying issue:

LPN: I know we had a First Nations nurse who was discriminated against by a couple of other nurses who refused to orientate her to the floor. Because she was First Nations, they felt that if she did poorly and they gave her a bad review that she would come back at them, as, you know it was discrimination. “That is why I didn’t do well” and I mean this was told directly to me by one of the nurses involved. You know one of the nurses who actually refused to do it. So it is not like gossipy information. That is direct information. I was absolutely speechless when she told me this and that was my thing when you, I think when you talk to a lot of nurses and they say “no I treat everybody the same.”

Although clearly distressed at her colleagues’ decision, there is a level of collegiality that she prefers not to jeopardize, foregrounding instead the nurses’ positive qualities:

No, I didn’t say anything. Again as a nurse that I like working with, and who has always treated me with respect, and as a team member, so no I didn’t say anything.
But she also, in her head, because she told me to my face, she said “I am not discriminating. I am not racist.” You know, she truly did not believe that what she was saying or doing was hurtful, you know, she’s not that. She is a good nurse. She is a wonderful nurse. So no I didn’t say anything. I have a good friend of mine who is an RN that we worked pretty much the same so I kind of vented to her afterwards.

And that was it. No I didn’t say anything to her.

This case provides a glimpse into the contradictions of democratic racism and how they can play out as nurses grapple with how to interpret an obvious breach in egalitarianism. In this situation, even when a racialized decision is identified it is viewed as an isolated phenomenon. Locating these practices and comments as stemming from the bad attitude of one individual diminishes the notion of racism as systemic and inherently embedded in our cultural values and democratic institutions (Henry et al., 2000).

However, First Nations nurses were concerned and affected by racist talk. The stress of dealing with everyday expressions of racism (and other forms of oppression) both within and outside the hospital was fatiguing. A First Nations nurse describes the additional level of stress this created within her work environment:

LPN: I don’t respond to those. I do not acknowledge those kinds of remarks because I don’t want to be – this is where I work. I don’t need this kind of stress you know. But you are right, there is discrimination as we speak. There is racial discrimination. There is prejudice in all kinds, as we speak. And this is why I’m, this is what I say, it would be nice to go back to this little posting [tapping on a newspaper advertisement for outpost nurses on my desk] – to be able to do these you know?

Part of the resignation expressed by this nurse stems from the recognition that she alone
cannot counter these dominant discourses. Instead, she calls on the personal strengths of First Nations nurses who must learn to operate within the mainstream sector:

LPN: But I think, I think to work as, to be an Aboriginal nurse, or an Aboriginal person to work in a field, in White man’s world so to speak, you have to be able to know your work. You have to be able to be strong. You have to be able to put your head up and say, “hey, I am just as equal as you are,” you know. That is, you know, I’d like to think we’re no different, that you and I are the same, but in some cases, in some people [whispering] it is not. You know.

Other First Nations nurses attempted to voice counter-perspectives, however, conditions had to be safe before they felt comfortable speaking up:

LPN: I think it depends on the situation. Like when there is a lunchroom group of people where I don’t know some of them and I do know some of them. Yah, I keep my mouth shut. Right or wrong I do. Because just as I have strong feelings, other people have strong feelings, and when it is one against ten, it’s intimidating, I am not going to say anything. But when it is with people that I know, then yah, I will, like when we were talking about that one guy who came in with the MVA, and their comments. And, and I did state “this man has nothing to do with the land claims.” Like I, you know, “he makes me want to cry, and you’re getting all angry.” So, absolutely, and only with people I feel comfortable with.

A: How do the nurses respond to you?

LPN: They’re very good, absolutely. They don’t agree with my stance, absolutely. And they don’t have to agree. That is not what I am asking. Just that they understand that there is another point of view that’s all.
Distinctions are also made about what constitutes discriminatory discourses. Negative comments or conversations directed in relation to First Nations patients were readily identified as examples of discriminatory discourses; nurses then faced the dilemma of whether to respond to these comments or not. Racialized comments framed as jokes – even when directed toward First Nations nurses themselves – were interpreted in a less serious light. For example, in a busy charting area where one First Nations nurse was sitting among other nurses, a Euro-Canadian nurse said to me in a loud voice, “you want to know about cross-cultural, ask her [nodding toward the First Nations nurse]: that’s not just a tan she has you know.” Field notes captured my discomfort with the comments and the laughter among nurses that followed. The First Nations nurse involved, however, did not share this sense of unease.

LPN: Oh, you see the thing is the nurses that I work with on [unit name] were just awesome, just awesome people, and I mean, it doesn’t, the last thing I’d look at is somebody’s colour. I look at their work performance and their work ethics and their philosophy and how they look at people and how they treat other people and, and that comment that was made, that was just, phew [gesturing with her hand as if to sweeping it away], you know. It was something that, I don’t know, you can look at it either way. You can say, oh she is just flippant or she is just making a fool or is it a compliment. But coming from her it is probably a joke and also a compliment because the thing is they know that I have been, I have nursed all kinds of different people.

A: Yah. So I was just wanting to ask about that.
LPN: I am glad you did, yah. Now the thing is it might, some other, if it was, if it got into the wrong type of a person, for example a person that has got low self-esteem or somebody that does not appreciate being a Native or does not, is not so proud of being a Native, you know, for somebody like that they probably might think that was an insult but for me I am proud of what I am.

Although personal strength acts as a buffer, earlier, this LPN described the stress she experienced at seeing “racial prejudice on the unit as we speak.” These varying interpretations of what constitutes discrimination and what is offensive or hurtful highlight the contextual and relational nature of intercultural relations. By shifting the focus away from individual interpretations of racist talk, we can more easily pull back and look at the wider issues underlying varying forms of racialized discourses. From this perspective, jokes about First Nations reinforce a collective self-identity among Euro-Canadian nurses that mark them as separate (Furniss, 1999). The repressive quality of these jokes or comments is compounded when other dominant group members condone, through their silence, what is being said; by failing to challenge or reject these comments, group power is sanctioned and reinforced (Essed, 1991). Nurses’ self-image as tolerant, neutral professionals is also reinforced as racist talk is redefined by First Nations and non-First Nations nurses as “just joking,” as unintentional, or as harmless. While these interpretations keep the peace, they inadvertently maintain the status quo. In the absence of any objections, racialized discourses at the workplace are seen as normal.

**Summary**

Without critically thinking about issues of race, racism and racialization, nurses cannot question processes that are presumed to be normal – according to the dominant group.
Racializing discourses among nurses provide a case in point: comments about First Nations nurses are interwoven into routine dialogues. Nurses are not purposefully engaging in exclusionary dialogues. However, these dialogues close off opportunities for counter dialogues. Nurses’ discourses operating as social practices therefore create an organizational climate that prevents critical engagement with issues of racialization or other forms of inequality (Henry et al., 2000). In the next and final chapter I consider the broader implications of discourses and ideologies that have contributed to the relative lack of critical consciousness in nursing about Aboriginal health, and discuss recommendations for future action.
CHAPTER NINE

IMPLICATIONS: THE SOCIOPOLITICAL CONTEXT OF ENCOUNTERS BETWEEN NURSES AND FIRST NATIONS WOMEN

Introduction

The central argument of this dissertation illustrates how dominant ideologies and professional discourses intersect to organize the knowledge and attitudes that nurses bring to their practice with First Nations women, and the relations of power that arise. These dominant ideologies and professional discourses are interwoven and reproduced in routine interactions involving nurses and First Nations women. In this chapter, I discuss the sociopolitical context of encounters between nurses and women in terms of the implications that can be drawn from the preceding analyses.

The first half of the chapter provides an overview of the empirical findings of this dissertation, and is organized into four sections corresponding to the preceding chapters. The first subsection provides a summary of the interpretive frameworks that nurses draw on to form their understandings of Aboriginal patients. The second examines how these frames of reference operate in practice to shape the relational aspects of nurses’ work with First Nations women. In the third subsection, I reconsider the contexts that give rise to First Nations women’s accounts of their hospital experiences and their interactions with nurses. In the fourth subsection, I briefly review the varying forms of racialized discourses that occur within health care settings among nurses in particular.

In the second half of the chapter, I examine more pointedly the factors that have contributed to the relative lack of critical consciousness in nursing about Aboriginal health, and the ensuing implications. As I explain, these arise in part from a general devaluing of hospital nurses’ intellectual work within institutions. I also argue that critical political and
social consciousness in nursing has been constrained by the liberal ideological values which underpin nursing knowledge. These factors in combination limit the extent to which nursing is prepared to problematize issues of ‘race’, racialization and culture as they shape health and health care for Aboriginal peoples.

I then turn to recommendations arising from this study. In forming these recommendations, I derive direction from the postcolonial theoretical perspectives informing this study. In particular, I consider how nursing might be better positioned to develop critical consciousness – knowledge that unmasks unequal relations of power and privilege, issues of domination and subordination, and assumptions about ‘race’, gender, culture and class relations (Anderson, 1998b). I argue that the postcolonial perspectives embedded within the theory of cultural safety have the potential to shift how nurses (and nursing) think about Aboriginal health, the burden of history shaping health care interactions, and the social and moral responsibilities that arise therein. In closing, I challenge nursing to consider how we can more fully activate our social praxis in relation to Aboriginal health in the postcolonial context.

**Overview of Empirical Findings**

**Nurses’ Interpretive Frameworks**

As nurses attempt to provide culturally sensitive care, they draw on a variety of theories, ideologies and discourses. In this study, three overlapping discourses informed nurses’ practice with Aboriginal women: (a) theories of culture, (b) liberal notions of egalitarianism, (c) and popularized discourses of Aboriginality. Undergirded by several common assumptions, these discourses formed the framework within which nurses related to First Nations patients.

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66 This phrase is borrowed directly from Furniss (1999).
Theories in nursing promoting cultural sensitivity or cultural competence have been helpful in drawing attention to how culture shapes responses to health and illness; this is required to provide good nursing care. Problems arise, however, when culture – conceptualized as a static concept – becomes the primary analytic lens for examining socially and structurally mediated issues, and issues related to power inequities. For example, explaining passivity or quietness as cultural characteristics of First Nations women can lead nurses to expect most women to be relatively non-communicative. The uncritical cultural model, which directs nurses to adapt their practices to stereotypical cultural characteristics, glosses over long-standing patterns of paternalism and authoritarianism shaping health care relations.

Cultural sensitivity itself is not problematic; rather, the culturalist assumptions embedded in the cultural sensitivity approach need to be problematized. For example, images of Aboriginal mothers as irresponsible or neglectful are pervasive in the popular media (Rutman et al., 2000; Tait, 2000b). These images influence the perceptions of health and social service workers who are quick to identify Aboriginal women as poor mothers (Browne & Fiske, 2001). Negative images reframed as cultural characteristics tend to become widely applied as markers of difference. Recognition of economic and structural disadvantages that continue to place women and children at risk are overlooked. In the process, culture provides the language with which to discuss value judgments about social problems in terms that downplay ‘race’ or racialization as the subtext.

To draw on another example, it was not uncommon for nurses to assume that “it is in their culture to have a lot of violence, stabbing and alcohol abuse, more than what you see in other cultures.” Without contextualizing the root causes of social problems, nurses conflate
Aboriginal culture with the cultures of poverty, substance abuse and dependency. Embodied representations of social problems encountered on a daily basis reinforce notions of Aboriginal peoples as Other (e.g., inferior, irresponsible, destructive). Unless a wider analytical gaze is applied, it is easy to gloss over the historical and structural issues contributing to Aboriginal peoples' disempowerment.

Images and discourses of Aboriginal peoples as dependent wards of the state, as “getting everything for free,” and as undeserving recipients of government benefits are pervasive in the popular press, media, and in public conversations (Furniss, 1999; Ponting, 2001). In BC, the treaty referendum in 2002 brought these discourses into sharp focus. Without strategies or perspectives that might otherwise enable nurses to think critically about these political and social issues, nurses take up popularized discourses. In the practice setting, these images and messages become benchmarks against which the Other is evaluated, even as they contradict nurses’ commitment to egalitarianism and colour-blind perspectives. In a clinical context, for example, dependency on the system becomes linked to dependency on pain medications or illicit drugs. From an uncritical vantage point, frequent encounters with substance using patients transform myths about Aboriginal weakness for alcohol or drugs into proof. Negative assumptions about Aboriginal peoples do not arise from the misinformed opinions of individual nurses: these are assumptions that are ingrained in Canadian consciousness. As Anderson (1991b) explains, “Health professionals speak from their position in the social structure, and reflect the dominant societal ideologies which sustain their position of dominance in relation to patients” (p. 112). By framing nurses’ racialized knowledge as reflections of socially shared knowledge, we can more easily locate the problem as socially organized, and ultimately, seek socially transformative solutions.
How Frames of Reference Influence the Relational Aspects of Nurses’ Work

Regardless of nurses’ faith in the clinic as a relatively neutral, egalitarian microcosm of society, assumptions about Aboriginal peoples, culture, and difference are interwoven and reproduced in routine interactions. Historical positioning, past experiences, and power differentials inevitably come into play and shape relations between nurses and First Nations women.

In the current climate of health care restructuring, the organization of nurses’ work – high patient workloads and growing staffing shortages – limits the extent to which nurses can attend to the emotional aspects of patient care (providing support, discussing patients’ concerns, etc.) (Varcoe & Rodney, 2002). Social exchanges between nurses and patients – moments in which small talk or humour is shared – help to establish points of connection that are part and parcel of the emotional labour of nursing. The social dialogues that transpire during these fleeting interactions are not insignificant. Chatting with patients, inquiring about even the most surface aspects of their lives, creates a common ground on which to relate to one another; these are indicators of social inclusion and recognition of shared perspectives. For example, nurses and Euro-Canadian patients quickly and easily exchanged brief conversations about knitting, the weather, grandchildren, or local craft fairs. Despite the hectic pace of nurses’ work, these kinds of social exchanges were routinely observed with Euro-Canadian patients. When First Nations women or men were involved, however, these interactions were only occasionally initiated by Euro-Canadian nurses. During these instances, it was typically the women who initiated brief dialogues about their home community or family life. My intent is not to suggest that Euro-Canadian nurses consciously distance themselves from First Nations patients. Rather, as I argue in Chapter Six, it is the
objectification of First Nations people as Other – produced through intersecting discourses of culture and dominant ideologies – that set the stage for social distances to be perpetuated.

Despite professional discourses that recommend cultural sensitivity, patients whose relational approaches differ from the anticipated norm – for example, those who do not engage in small talk, do not speak up, or do not pose frequent questions – tend to be overlooked as competent social players. Relating with these patients can be a source of frustration for nurses. A circular process of social distancing begins as First Nations women are viewed as being beyond the reaches of routine social interactions, and First Nations women respond to nurses with reticence. Unrecognized, however, are the varied and complex reasons that may underlie some women’s quietness: these may include, for example, conditioned patterns of responding to power and authority, intimidation, resistance, or the need to be seen as a good, undemanding patient. Without frames of reference that tune nurses into these factors, an awareness of why some patients are quiet or inexpressive and others are talkative cannot develop.

Of what consequence are patterns of social distancing in the context of nurse-patient encounters? In Chapter Seven, I argue that the potential to engage in the emotional labour of nursing is diminished; points of connection during which emotional support, concern or caring may be conveyed are less likely to develop. While bodily care or basic patient safety were not compromised, misconceptions and myths about Aboriginal peoples influenced the way nurses related to First Nations women. For example, First Nations nurses recounted repeated situations in which Euro-Canadian nurses, acting on presumptions about Aboriginal peoples as vectors for lice, scabies or TB, unnecessarily protected themselves by gowning and gloving. These acts of self-protection, while seemingly innocuous, mark First Nations
patients as Other. These sometimes overt patterns of relating – looks, gestures, tone of voice and verbal exchanges – contribute to social distancing during routine interactions.

While not intentional, varying forms of Othering practices are integrated into routine situations, activating underlying power relations. An example provided in Chapter Six illustrated how power dynamics can be played out in relation to routine ward privileges. A nurse’s reaction to a First Nations woman who needed to use the ward phone provided a glimpse into the workings of power differentials and how these are shaped by perceptions of patients’ gendered, classed and racial locations. From the nurses’ interpretive stance, the Aboriginal woman in question embodied assumptions about the Other as indigent, broke and dependent on the system. In the end, she was granted phone privileges, but not without disgruntled glances and responses. This, as McConaghy (2000) reminds us, represents but one of the countless ways in which minority subjects are scrutinized and objectified in routine situations.

Despite these distances, observable and obvious points of connection were established between some nurses and patients. Letting their professional guard down, speaking with patients about their community and home situations, and conveying sincere concern through non-verbal gestures and tone of voice resulted in qualitatively different patterns of interaction. These were, however, the exception rather than the rule.

Both patients and nurses get caught up in a complex interplay of social and historical positioning. While not observed directly, First Nations and Euro-Canadian nurses described how patients’ visitors sometimes reacted with anger when asked to leave the ward. In some cases, visitors claimed that such requests were made on prejudicial grounds. Having to respond to accusations of discriminatory treatment, nurses described their concern with
“watching out for the angry types” who “are always sort of on guard or play that card.”

Because of these experiences, nurses and patients tread cautiously. Guarding against how the Other will react adds to social distances; in the process, the ability to establish points of connection become precarious.

Reconsidering First Nations Women’s Perspectives

One of the unanticipated findings of this research was the extent to which First Nations women turned their analytic gaze inward to consider how they could best fit into existing health care dynamics and routines. Rather than questioning or critiquing the culture of health care, women’s accounts of their immediate hospitalizations were constructed around the theme, “all the nurses were good.” To unpack the layers of subtext embedded in this construction requires attention to methodological considerations (how and why women may have portrayed their experiences the way they did) and to the mediating circumstances of everyday women’s lives.

Methodological Considerations

An important methodological issue to consider as women’s perspectives are interpreted and conceptualized is how First Nations women constructed their nurses and hospital experiences for me as a Euro-Canadian (seemingly) influential nurse/professor/researcher. Given my position of power and privilege, how could women critique the services or the system with which I was so strongly affiliated? Patients are in vulnerable positions; disclosing dissatisfaction to an agent of the institution risks jeopardizing the care that women urgently need. These are very legitimate reasons for patients to keep their critical gaze in check.
Other factors are at play. In this study, the hospital is the institution of last resort for many smaller communities. People must believe that the health care they receive will be no less than excellent. In addition, patients’ expectations may be lowered in light of the crisis in health care so frequently portrayed in the media. Pleased to be getting any care at all, patients may feel genuinely appreciative.

There is another line of analysis to consider. Internalization of colonizing experiences – the long-standing relations of power, authority, paternalism and forced dependency on health care and other sectors – influences expectations of health care. Stories recounted by some women about past health care experiences depicted extreme examples of mistreatment; these shape expectations of how women or their family members may be treated in the future. From this vantage point, being provided with even the most basic care may be interpreted as positive; expectations for anything more do not figure into the equation.

It is impossible to determine the extent to which my social and professional positioning influenced women’s narrative accounts. Nor did the methodological approaches I used intend to control for what some might label social desirability bias. However, we must consider the angles from which patients construct their evaluations of hospital experiences. To do otherwise – to accept at face value that “all the nurses are good,” that patients are completely satisfied, and that there are few gaps in health care – will provide an incomplete analysis.

The Mediating Circumstances of Women’s Lives

Women’s accounts of their hospital experiences must be interpreted within the material, social and personal contexts of their lives. Several women faced daily struggles as they attempted to survive on meagre social assistance payments. To manage pain, one
woman described how she procured analgesics by purchasing them on the street at great risk to herself. When admitted to hospital, she was immensely appreciative of the medication that relieved her chronic pain. For some women, nurses (and nurse’s aides) who checked on them or delivered medications on time were providing high quality care. For one woman, being addressed by a nurse as “sweetie” was interpreted as caring. What I might read as social distancing or an objectifying remark may be interpreted quite differently by patients for whom certain actions carry different symbolism.

Contrary to nurses’ views of women as passive, women made active efforts to navigate the system by “getting along” with their nurses. Women mobilized a variety of approaches: they were uncritical, patient, and undemanding. Throughout a lengthy hospital stay, an elderly woman rarely if ever used the call bell. Another woman in her early forties used her social skills and sense of humour to “win over” a nurse that other patients described as “sergeant-like.” For this woman, activating her sense of agency represented an act of resiliency and resistance in light of prior tragic experiences with health care as a young woman.

Women were clear that responsibility for getting along with the nurses rested on their shoulders. Recognizing that the impatient or oppositional behaviours displayed by other First Nations women could influence their nurses’ perceptions of them, women worked hard to be seen as good patients. Responsibility for countering negative images reinforced the principle, “it all depends on how you treat the nurses.” Understanding the pragmatism embedded within these perspectives illustrates the importance of interpreting women’s accounts of their hospitalizations in light of their historical, cultural and social positioning.
Racialization in Health Care Settings

In an environment of permissiveness, racialized values and assumptions are given expression in informal, everyday conversations. Dominant discourses about Aboriginal peoples were not only applied as a lens for viewing patients; First Nations nurses were also constructed in ways that objectified them as Other. In making these visible, the intent is not to implicate individual nurses; rather, these discourses provide a window into the workings of racialization within supposedly egalitarian public institutions.

Euro-Canadian nurses who discuss issues related to Aboriginal peoples or the politics of Aboriginal-state relations do not, most often, intend to offend. Quite the opposite: jokes about skin colour, off-handed comments about land claims or Aboriginal patients’ penchant for pain medications are so routine and acceptable, they have come to be seen as normal. These seemingly innocuous jokes and comments, however, have a social function: inadvertently they reinforce a collective identity among Euro-Canadian nurses that simultaneously marks First Nations nurses as outsiders.

These discourses occur in informal discussions among nurses – at charting desks, in medication rooms – and are contained in spaces away from patients. Nonetheless, they are revealing in their casualness. Reimer Kirkham (2000) reminds us that it is not the actual comments that are the issue, but rather, the extent to which they sustain dominant discourses and preclude counter-discourses. First Nations nurses, who are usually the only First Nations staff people in the vicinity, tend not to express opposition or offer an alternative perspective. Rather, behind-the-scenes discourses were framed as the thoughtless opinions of particular individuals. Committed to maintaining collegial relations, First Nations nurses do not tend to confront racist talk. This too has a function: the significance of wider ideological messages,
which so clearly seep into the workplace, are diffused. At the same time, First Nations nurses express a certain resignation that they alone cannot counter dominant expressions of group power.

**Implications: Constraints on Critical Analysis in Practice**

Without tools or strategies for thinking critically about issues of culture, history, or ‘race’, evidence of racialized relations in health care goes largely unrecognized by most health professionals. For example, nurses in this study were largely unaware of how dominant discourses – taken up as common-sense knowledge – factored into their relations with First Nations patients. In part, this lack of awareness stems from wider institutional and disciplinary discourses that espouse the values of egalitarianism, colour-blindness and respect for diversity. Together these create an organizational climate that prevents active engagement with racial and other forms of inequality. As long as the possibility of racialized relations is ignored or overlooked, there remains no need for counter actions (van Dijk, 2002). The consequence is that discourses operating as social practices reinforce the status quo (Henry et al., 2000).

In this study, First Nations nurses’ social experiences, cultural identities, and educational preparation attuned them to racializing discourses and practices. Holding up for scrutiny what their Euro-Canadian colleagues tended to take for granted, First Nations nurses arrived at very different conclusions. This does not imply that non-First Nations nurses are constrained by their social and cultural locations. Rather, as Cairns (2000) reminds us, “We are all informed and shaped by our individual past experiences – informed and shaped, but of course, not controlled” (p. 11). Several fundamental factors, however, continue to limit rather than foster nurses’ critical thinking about wider sociopolitical and historical issues.
influencing relations within health care. These relate to the limited value placed on nurses’ intellectual work within institutions and among some practicing nurses, and the liberal ideological underpinnings of nursing knowledge.

_Devaluing the Intellectual Work of Nursing_

Critical thinking can be conceptualized as one dimension of nurses’ intellectual work. The notion of intellectual work is borrowed from Varcoe and Rodney (2002) to delineate the reflective, thinking aspect of nurses’ work. This does not imply that intellectual work is separate from emotional labour or bodily care; rather, each informs the other. For discussion purposes, however, it can be useful to apply a label to nurses’ intellectual work to distinguish it from the kinds of non-nursing, task-oriented work frequently assigned to hospital nurses.

Nurses’ work, organized around an ideology of scarcity in health care, tends to devalue the intellectual aspects of practice (Varcoe & Rodney, 2002). Institutionalized efficiencies require nurses to focus their energy on providing physical care at the expense of emotional care, and nurses are often assigned non-nursing tasks. This sense of “scrambling, running and worrying about missed aspects of patient care” has become characteristic of hospital care and conveys a lack of coherent organizational support for the full range of nursing work, including intellectual work (Lynam et al., in press, p. 8).

In work environments that undervalue nurses’ intellectual contributions, fostering an appreciation for new kinds of political and social consciousness is difficult. Resistance also comes from within the profession. Scepticism about the benefits of higher education limits some nurses’ engagement with intellectual endeavours. A diploma-prepared nurse explains this perspective:
RN: You know, I find the degree nurses have a tendency to overanalyze. They want to know more than they need to know to do the job and that is fine if they do it on their own time but some of them have a tendency to go looking for some reference book to find out what exactly this disease is, when their role is not to, they don’t need to know that, I don’t think, to do their job. And that is fine and well if you want to do community work which is where basically degree nurses should be... Staff nurses at the hospital, you don’t need that to work there. Just as long as you know your stuff and have a little bit of common sense.

Disinterested in studying content related to Aboriginal issues, another nurse described how she decided to transfer out of her baccalaureate program because of content focused on First Nations health in nursing courses. These kinds of perceptions are not isolated opinions; they reflect ongoing conflicts within our discipline about the value of higher education.

While not wanting to diminish the urgent need to restructure nurses’ work environments so that more time and space is available for intellectual work, I suggest that time is not the only issue. Assuming that knowledge of historical/structural contexts has the potential to shift nurses’ attitudes and perspectives, the more fundamental issue is how to cultivate an awareness of these dimensions of critical thinking as beneficial to nursing practice. Drawing on her experiences teaching theory related to cultural safety, Ramsden (2000) argues that it is not time but nurses’ ability to recognize the wider context of racializing experiences and respond to power differentials that contributes to trusting relations. As she writes, “The trust moment may be fleeting and unspoken but the information load is high and influences all future interactions... If trust does not happen very
early in nursing interactions, people will continue to protect their difference from nurses” (p. 10).

To develop critical consciousness will require educational strategies and frameworks that focus on the responsibilities and implications of practising nursing in a postcolonial context where ‘race’ and power continue to create patterns of inclusion and exclusion in health care settings. The challenge for nursing, then, lies in maintaining “an overarching mindfulness of how domination and resistance mark intercultural health care encounters at individual, institutional, and societal levels” (Reimer Kirkham & Anderson, 2002, p. 10).

Despite a growing body of critical scholarship in nursing and increasing calls for critical analyses, these are not typically the subjects that engage us as a discipline (Allen, 1999; Drevdahl, 1999; Meleis & Im, 1999).

**Recognizing the Liberal Ideological Underpinnings of Nursing Knowledge**

Before we can question the theories and discourses influencing our understanding of Aboriginal health, nursing must first of all critique its own complacency with the ruling relations as they are enacted in education, practice, research and theory. To move nurses in the direction of “transformative knowledge for transformative social action” (Anderson, 2000a, p. 225), we must first of all critique the theories and ideological assumptions that underpin our disciplinary knowledge. Transformative knowledge is defined by Anderson (1998) as knowledge that is “undergirded by critical consciousness on the part of the healthcare providers and that unmask inequalities of power and issues of domination and subordination, based on assumptions about ‘race’, ’gender’, and class relations” (1998, p. 205). Critical analyses of these concepts, however, are not well developed in nursing
education or theory in large part because they challenge the liberal ideological values on which our science is based.

Nursing knowledge (like other health sciences) has been largely built on liberal notions of abstract, freely choosing individuals who exist in an essentially equitable society (Browne, 2001). These premises are manifested in relation to the individualistic focus of nursing theories, a preference for (supposedly) politically neutral knowledge development, and a lack of attention to structural determinants of health and illness despite persistent racialized, classed, and gendered health inequities.

Despite attempts to claim political neutrality, the implicit stance of several of nursing's prominent theorists clearly reflects liberal ideological principles (Browne, 2001). These theorists explicitly advocate for a philosophical position for nursing theory which is firmly grounded in libertarian notions of people as inherently rational and as freely choosing their own patterns of existence (see for example, Mitchell & Cody, 1992; Newman, 1990; Parse, 1997). The result has been a growing body of knowledge in nursing that espouses and reinforces libertarian notions of free choice, equality of opportunity and individualism, and that presents patients as persons who can be cared for in isolation of their material and social contexts (Thorne, Canam, Dahinten, Hall & Reimer Kirkham, 1998).

This trend in nursing theory persists in spite of nurses' daily contact with embodied consequences of social and structural inequities. Without the tools to situate patients' experiences in the larger context of mediating sociopolitical, economic and historical forces, nurses inevitably make sense of difference in ways that "succumb to racialization, Othering, and reinforcement of existing power inequities" (Reimer Kirkham & Anderson, 2002, p. 9). Frameworks that prompt us to theorize about culture in ways that account for the shared
meanings within groups without giving way to stereotypes would better enable nurses to
counter popularized assumptions about Aboriginal peoples as dependent on the system, as
quiet, spiritual patients, or as irresponsible mothers. The objectification inherent in behind-
the-scenes comments like “there’s your land claims for you” might be more readily
recognized. Basic knowledge of Canada’s colonial history and the current workings of
internal colonialism might result in more nuanced understandings of Aboriginal-state
relations, the sociopolitical determinants of Aboriginal peoples’ health, and the power-laden
nature of health care interactions. These are not, however, typical areas of study within
nursing.

While not intended as such, relating to Aboriginal women as objectified Others is a
political act. Fostering an understanding of the political nature of our nursing practice –
particularly in relation to patients who are disproportionately disadvantaged by politically
mediated social conditions – will be required to shift entrenched attitudes. Strategies will be
needed to make transparent the political ideological underpinnings of our attitudes,
knowledge and practices related to Aboriginal peoples, even when we assume a seemingly
neutral, apolitical position.

Principles of political neutrality tend to operate in nursing education, research, theory
and practice in ways that support a politically conservative disciplinary disposition (Browne,
2000, 2001). To counter these tendencies and critique the status quo, discourses in nursing
(and the wider field of health care) are needed to help nurses locate their interactions within
the wider context of internal colonial relations. Otherwise, our supposedly apolitical stance
will continue to (naively) reflect and perpetuate, rather than challenge and disrupt,
neocolonial ideologies, images and discourses about Aboriginal peoples.
as I have attempted to show through the analysis presented in this dissertation, nursing practice is not apolitical. To the contrary: the persistent oversimplification and neutralization of politically charged concepts such as 'race', culture and racism in nursing have (inadvertently) resulted in discourses that support subtle forms of democratic racism (Culley, 1996). If, as Essed (2002) claims, access to knowledge about the nature of domination and inequities leads people to accept more responsibility for changing their practices, nursing must view critical analyses of these issues as central aspects of nursing education, research, theory and practice. Essed's line of argument applied to the points raised in this dissertation signals a need for nursing knowledge focused on the historical context of Aboriginal health and ongoing processes colonialism before nurses can critically locate their interactions within the wider context of politically charged health care relations.

**Fostering Critical Political and Social Consciousness:**

**Applying Postcolonial Perspectives from Cultural Safety**

The social and moral mandate of nursing is now understood to include analyses of how oppressive social structures constrain health and access to health care particularly for those marginalized within society and health care (Meleis & Im, 1999; Reimer Kirkham & Anderson, 2002; Thorne et al., 1998). How then can we as nurse scholars, researchers and educators advance the development of critical political and social consciousness among practicing nurses? What strategies or frameworks can increase awareness of our own positioning within the ruling relations (Smith, 1992)? How can more nurses see how their sociocultural and historical positioning structures their world view and the discourses they take up? How can they gain more insights into their own interpretive stances and how these influence relations with patients? In forming my responses, I return to the postcolonial theoretical perspectives discussed in Chapter Three. In particular, I put forward an analysis of
how the theory of cultural safety embedded within postcolonial perspectives can push these lines of thinking and provide an alternative to the culturalist approaches that predominate nursing theory.

The postcolonial framework of cultural safety provides direction for the development of sociopolitical insights about the disparate power relations within and beyond health care, and the historical and social processes that organize these relations (Ramsden, 2000; Reimer Kirkham et al., 2002). More specifically, the theory of cultural safety directs nurses to examine not only unequal health care outcomes and experiences, but also the long histories of economic, political and social subordination that contribute to current health and social conditions for Aboriginal peoples and other racialized groups. By restoring history and politics to prevailing ahistorical understandings of culture (Narayan, 2000), cultural safety reminds us that it is less powerful to develop knowledge about cultures than to develop knowledge about how societies at large, and health care systems in particular, tend to marginalize patients because of their culture (Meleis, 1996).

At the level of nursing practice, cultural safety does not presume to prescribe or define a set of behaviours or attitudes that can be deemed culturally safe. Instead, nurses and patients reappraise their exchanges as culturally safe or unsafe depending on their interpretive standpoint, past experiences, and historical and cultural positioning. Reimer Kirkham et al. (2002) explain this point: “cultural safety is not an entity, fact, or process that can be identified in a realist sense. Rather, cultural safety is constructed through interaction within particular contexts” (p. 228). Cultural safety, then, may be best conceptualized as a theoretical lens through which to examine how the politics of history, ‘race’ and
social/cultural/gender positioning are played out in health care interactions to sustain or disrupt colonizing relationships.

Increasingly, it is recognized that health professionals who relate to patients on the basis of dominant assumptions and stereotypical attitudes jeopardize the delivery of services (Papps & Ramsden, 1996). Papps & Ramsden explicitly argue that “Nurses cannot provide quality, patient focused care if they have unconscious negative attitudes towards patients who are different from them” (p. 496). For patients, the consequence may be avoidance of a health system that does little to recognize or alter patterns of individual and institutional discrimination. The high rates of preventable admissions to hospital recently documented among status First Nations in BC, for example, would suggest that problems with the availability and acceptability of front-line health services have contributed to the apparent reliance on secondary or tertiary interventions (BC Provincial Health Officer, 2002).

To engage more fully in socially transformative praxis we need to critique how nursing may be inadvertently reproducing long-standing patterns of inclusion and exclusion. One feature of postcolonial praxis is its “open commitment to critiquing the status quo and building a more just society” (Reimer Kirkham & Anderson, 2002, p. 13). The challenge is how to engage in praxis when we are socialized to uncritically accept dominant ideological discourses about Aboriginal peoples as normal, when racialized discourses permeate nurses’ workplaces, and when professional discourses and theories downplay sociopolitical analyses.

Nurses do not intentionally take-up colonizing discourses or seek to establish socially distant relationships with First Nations women. To the contrary, “organizations and institutions… 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 racial inequality” (Henry et al., 2000, p. 383). Herein lays the value of cultural safety in redirecting nurses to think critically about Aboriginal health and wider issues of social justice.

**Understanding the Burden of History**

Incorporating perspectives from cultural safety into Canadian nursing discourses would attune us to the history of mistrust that has characterized health care relations as they evolved in relation to Aboriginal peoples. As Ramsden (2000) argues, this history – with its adjuncts of authoritarianism, paternalism/maternalism and disempowerment – must be understood in order to change practice. Historical perspectives provide a lens for viewing our current practices. Specifically, cultural safety would require us to examine our interactions with First Nations patients in fields of power relations, as mediated by current colonial relations, and as being continually reinterpreted and renegotiated in light of wider social and political forces (Reimer Kirkham et al., 2002).

The line of analysis offered by cultural safety differs significantly from the culturalist approaches typically taken in health care and nursing education, which are geared to providing nurses with more cross-cultural training. The latter approach assumes that more information about Aboriginal cultures will improve nurses’ sensitivity to Aboriginal patients. Romanow’s (2002) recent report on the future of health care in Canada reiterates this valuing of cultural sensitivity “training for non-Aboriginal health care providers so they are in a better position to meet the health needs of Aboriginal communities” (p. 220). Cultural safety, however, takes us in a fundamentally different direction: it asserts that more knowledge about Aboriginal cultures will do little to shift deeply embedded attitudes toward the Other (Ramsden, 2000). Cultural safety intentionally shifts the focus away from Maori cultural
practices per se, so that nurses can begin to disrupt culturalist images of Maori culture and popularized stereotypes (Papps & Ramsden, 1996). Instead, emphasis is placed on transforming attitudes, policies and practices in health care by gaining an awareness of the political, economic and historical forces shaping the health and social status of indigenous peoples (Kearns & Dyck, 1996). As Ramsden (1993) writes,

> Extinguishment of stereotype is fundamental to introducing nurses to the range of people who come within a definition of Maori....Nurses in New Zealand, without the benefit of a broadly based social education, were confusing the cultures of indigenous people with the culture of poverty into which the indigenous people have been driven. It follows then that cultural safety requires nurses to become expert in understanding the poverty cycle and the various histories and socio-political conditions which establish and maintain it. (p. 3)

The point is not to preclude attentiveness to cultural meanings of health and illness; recognizing and responding to the tremendous diversity among Aboriginal cultures is part of relevant, socially responsible nursing care. However, cultural knowledge without attention to structural, political, historical and gendered constraints has the potential to further marginalize and disadvantage patients (Meleis & Im, 1999). This represents another fundamental difference: the focus of analysis from the perspective of cultural safety is not on cultural differences but on the health care system and health professionals. This would prompt us to critique, for example, how we relate to Aboriginal patients, how our underlying assumptions are socially mediated, and how our relations with Aboriginal patients reflect broader sociopolitical and historical issues.
Viewing health care encounters through the postcolonial lens of cultural safety would lead us to examine how First Nations patients are affected by the culture of nursing and the dominant ideological messages transmitted to patients. Cultural safety brings into focus the political dimensions of our relationships with First Nations patients (and other racialized, marginalized or disempowered patients). In the process, we will be asked to examine how we manage our attitudes, our power and our social-cultural positioning vis a vis patients (Ramsden, 2000).

The focus of this discussion is not intended to overshadow the experiences and insights of First Nations women interviewed in this study. As discussed in Chapter Seven, First Nations women – themselves positioned within historical, social and cultural locations – bring assumptions, contribute to relational distances, and guard against the Other (in this case nurses). Interacting from differing positions of power and privilege, women also made efforts to get along with the nurses and navigate within the hospital as good patients. These factors figured prominently in how women constructed their perceptions of nurses and hospital experiences for me as a Euro-Canadian nurse-researcher. Postcolonial perspectives remind us to consider women’s accounts of their health care experiences in light of historical patterns of relating that endure in the present, and to unveil the power dynamics and social relations that inevitably shape women’s experiences and their accounts of these experiences.

A postcolonial reading of epidemiological indices of health and illness for Aboriginal populations would inform an understanding of how the ongoing effects of colonial oppression continue to be manifested. Such a reading would counter the tendency of health statistics to reinforce images of communities as sick, disorganized and dependent (O’Neil et al., 1998). Similarly, examining the social determinants of health for Aboriginal populations...
from a postcolonial perspective would help us to see more clearly, for example, the links between historical oppression, current aspirations for self-determination, and health in its broadest sense.

The discussion I am advancing is not intended to suggest that all nurses study specific content related to Aboriginal health. However, understanding the factors that shape Aboriginal peoples' health and social wellbeing provides a window into the workings of historical, economic and political oppression; these lessons will help nurses to understand how other racialized, marginalized or disempowered groups have been similarly oppressed, through vastly different processes. For example, examining the premises and policies of Canada's Indian Act alone would tune nurses into wider sociopolitical issues shaping health and health care. At the very least, a critical discussion of these issues would orient nurses, educators and scholars to "how gender, race, class and historical positioning intersect at any given moment to organize experience in the here and now" (Reimer Kirkham & Anderson, 2002, p. 15).

**Resisting the Pull of Political Conservativism**

LaRocque (2001) argues that most university programs fail to prepare students to think critically about cross-cultural or multi-racial contexts; this too is a political issue. As LaRocque writes, "Politics enters our classrooms as well when students (both First Nations and non-First Nations) deeply conditioned to assume the universality and objectivity of the Western narrative, do not or will not understand the political nature of history, representation and epistemology" (p. 71). Without systemic support for critical pedagogies in universities (and in nursing programs in particular), approaches to learning that might foster critical consciousness tend to be lacking. Furthermore, in an increasingly conservative political
climatè, students (and teachers) may be resistant to critical analyses of Canadian history or dominant culture.

Nurses (and nursing as a discipline) should resist this pull toward political conservativism. Nurses must be able to think critically about the ideology of democratic liberalism, the notion of democratic racism, how claw-backs to the social safety net reflect economic policies, and how certain groups are disproportionately disadvantaged. Socially transformative praxis and goals related to social justice must be extended to include Aboriginal health. I am not suggesting that nurses assume advocacy roles without community partnerships; first and foremost, nurses must work with communities to address community-driven goals. To date, however, few nurse leaders in Canada have formed the kinds of partnerships that would permit them to take up the issue of Aboriginal health. Similarly, with some exceptions, few nurse scholars have demonstrated leadership in Aboriginal health; nursing research has also been very limited. Consequently, Aboriginal health has not been well profiled as an area of concern for nurses in textbooks, nursing journals, courses, research conferences or at the practice level. Furthermore, without a critical mass of Aboriginal nurses in leadership, practice and education, Aboriginal health continues to fall outside the realm of mainstream nursing education and research.

Where does this leave us? Essed (1991) argues that, "within specific boundaries individuals can make their own choices. They choose how they act. They either uncritically accept a dominant representation of reality or seek alternative views....once they understand

67 For the past 29 years, the Aboriginal Nurses Association of Canada (ANAC) has played a central role in promoting Aboriginal health initiatives and recruitment of Aboriginal nurses (Aboriginal Nurses Association of Canada, 2002). In December 2002, however, the ANAC had to cease operations due to cuts in core funding from federal sources and a lack of funding from other sources. As ANAC Executive Director Bernice Downey writes, "It is ironic that in light of the health needs of Aboriginal community members, which have been well profiled in the recent Romanow Report...that a long-standing and significant contributor to the nursing workforce and Aboriginal health initiatives for Aboriginal people is being forced to close" (ANAC, personal communication, December 4, 2002).
the processes of domination” [italics added] (p. 46). Although I disagree with the emphasis placed on individual responsibility, regardless of historical, educational, or social location, Essed’s arguments raise some provocative questions for nursing. Without frameworks that foster critical consciousness, how can nurses engage critically with dominant perspectives, remain open to alternate viewpoints, or counter racialized discourses? Are nursing programs and educators prepared to wrestle with difficult issues related to culture, ‘race’, racialization, and social inequity? To be sure, deeply engrained attitudes and practices will be difficult to shift. Cultural safety with its postcolonial attention to the sociopolitical context of nurse-patient encounters, however, will be a catalyst in this process.

**Overall Recommendations Arising from the Study**

Speaking directly about the responsibility of scholars to address issues of colonization, oppression and domination, LaRocque (1996) writes, I find it impossible to study colonial history, literature, and popular cultural productions featuring Native peoples, particularly women, without addressing the social and ethical ramifications of such study. To study any kind of human violation is, ipso facto, to be engaged in ethical matters. And we must respond – as scholars, as men and women, Native and white alike. These destructive attitudes, unabashed biases, policies and violence that we footnote cannot be mere intellectual or scholarly exercises. They do affect native peoples, real human lives. (p. 12)

As nurses, we must make space for analyses of politics and history, and how these have variously positioned us, shaped people’s health, and structured our relations with one another; only then can we work to transform these relations.
Based on the outcomes of this study, the following recommendations have been formulated. These are suggested to provide direction to nursing educators, practice leaders and researchers as they consider how to expand their foci in the area of Aboriginal health. They are deliberately contained within a few brief points to make them as accessible as possible.

1. Recognize the limitations of cross-cultural training models and cultural sensitivity approaches to training.

2. Examine the theoretical and practice-oriented guidelines embedded within cultural safety as an alternative to conventional modes of cross-cultural training for nurses and other health professionals.

3. Include critical political analyses of the Indian Act and current social determinants of health for Aboriginal populations as basic content in nursing education programs. Focus on how health (in its broadest sense) and health care affecting Aboriginal peoples are historically and structurally mediated. This can be accomplished through case studies or community-based scenarios, for example.

4. Develop linkages with Aboriginal communities in order to incorporate and teach the content outlined in the preceding recommendations.

5. The content recommended in numbers 3 and 4 above could provide the basis for training modules for practicing nurses.

6. Provide opportunities for nurses and students to visit and interact with Aboriginal communities or agencies as a way of challenging assumptions, stereotypes and dominant images.
Concluding Comments

Kelm (1998) has argued that, "A deep understanding of the nature of colonial relations and of their impact upon Aboriginal lives, in this case particularly referenced as 'health', is essential to any process that seeks to undo the racist teachings in our history and to promote social and political change" (p. xxiii). Explicating the historical and sociopolitical context of relations between nurses and First Nations women contributes to this process.
Nursing as a discipline must consider how committed we are to unravelling the intricacies of racism and to engaging in the political activity of social transformation. To begin, we must hold up for scrutiny the theories, discourses and assumptions that shape our understanding of Aboriginal health and our interactions with First Nations patients. As Smith (1990) reminds us,

what we make here an object of investigation is what we ourselves are immersed in.
The ideological practices explicated here are our own. Explicating such practices enables us to become aware of how, in deploying them, we participate in the relations of ruling. (p. 4)

LaRocque (1993) is clear about the roles of Aboriginal and non-Aboriginal peoples in social transformation: “The onus for change cannot rest solely on Aboriginal shoulders. White people in positions of power must share the burdens of finding answers, as they have been part of the problem” (p. 76). We might begin, as Audre Lorde has urged, by recognizing “that piece of the oppressor which is planted deep within us” (1984, p. 123). Turning the critical gaze inward may be disconcerting to those of us who see ourselves as being critiqued and challenged; this is inevitable as dominant discourses and practices are scrutinized. However, we must interrogate our taken-for-granted assumptions about the Other.
Contextualizing the complexities of health care encounters in today's postcolonial climate will allow us to confront deep-rooted attitudes and relations of power. By locating health care interactions within these wider historical and sociopolitical contexts, nurses can more fully contribute to social justice in the realm of Aboriginal health.
REFERENCES


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Appendix A

Informational Pamphlets for Nurses and Patients

(Information has been modified to protect the anonymity of the research setting.)
WHO IS DOING THE RESEARCH?

THE NURSE-RESEARCHER:
Annette Browne, RN, MSN, PhD(c)

HER PROFESSOR/SUPERVISOR:
Joan Anderson, RN, PhD
School of Nursing, UBC

ANY QUESTIONS?

ABOUT THE PROJECT:
Annette Browne, Nurse-Researcher

or
Dr. Joan Anderson,
Annette’s Professor and Supervisor
Phone: (604) 822-7455

ABOUT THE RIGHTS OF A RESEARCH PARTICIPANT:
Director of Research Services,
University of B.C.
Phone: (604) 822-8598

INTRODUCING A NURSING RESEARCH PROJECT:

Cross Cultural Interactions Between Women and Nurses
**WHAT IS THIS PROJECT ABOUT?**

Annette Browne, RN, MSN, is a PhD Student in the School of Nursing at UBC. She also teaches in the Nursing Program at UNBC.

This research project is being done as part of her PhD thesis.

- The goal of the study is to learn more about cross-cultural health care involving nurses and women.

- To do this, Annette would like to interview nurses and women who are in the hospital.

- She would also like to accompany nurses as they work with women in the hospital.

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**IF YOU AGREE TO PARTICIPATE, ANNETTE WOULD:**

- Accompany you for 3-4 hours of your shift as you provide care to women.

- Talk with you about your experiences providing cross-cultural care at a time and place that is convenient for you.

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**VOLUNTARY PARTICIPATION:**

- There is no obligation to participate in this study and you can withdraw at any time.

- Your participation will not require any additional time or interfere with your practice.

- Your participation will in no way affect your employment or performance evaluations.

- This is not an evaluation project.

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**PROTECTING CONFIDENTIALITY**

- Names or identifying information will not be used in the study or in any reports or publications.

- Hospital employers or managers will not have access to any of the information you provide.

- All information will be securely locked in Annette’s office.
Who is Doing the Research?

The Nurse-Researcher:
Annette Browne, RN, MSN

Her Professor/Supervisor:
Joan Anderson, RN, PhD
School of Nursing, UBC

Any Questions?

About the Project:
Annette Browne, Nurse-Researcher
or
Dr. Joan Anderson,
Annette’s Professor and Supervisor
Phone: (604) 822-7455

About the Rights of a Research Participant:
Director of Research Services,
University of B.C.
Phone: (604) 822-8598

Care to Be Involved?

Introducing a Nursing Research Project:
Women’s Health Care Experiences
What is this project about?

- Annette Browne is a Registered Nurse doing this research for a graduate university degree.

- The goal is to learn more about women's health care experiences and cross-cultural care involving First Nations women and nurses.

- To do this, I am talking with First Nations women who are in hospital and to nurses.

- I am also observing nurses as they work with women in the hospital.

Would you let Annette come and talk with you about this research project?

Please tell ____________________ if you would like to know more about this project.

Thank you for your time!

If you volunteer

- You do not have to be in this study.

- You can quit the study at any time and for any reason.

- Your health care will not be affected in any way.

Privacy/Confidentiality

Total privacy and confidentiality is ensured:

- Your name will not be used in the study or in any reports written about the study.

- Information that could identify you or anyone else will not be used.

- Hospital staff will not have access to any of the information you provide.

- All information will be securely locked in Annette's office.
Appendix B

Consent Forms

(Information has been modified to protect the anonymity of the research setting.)
Appendix C: Interview Guides
Interview Guide for Nurses

1. Tell me about the patients you care for on this hospital unit.

2. Tell me about your experiences caring for First Nations patients/women.

3. Tell me what it is like to work at the hospital.

4. Is there anything else that you would like to comment on or ask of me?

Interview Guide for First Nations Women

1. Tell me about your experience in the hospital.

2. Tell me about the nurses who worked with you in the hospital.

3. If you could give advice to the nurses about how to best care for you, what would you tell them?

4. Some patients feel that they are not given the same health care that other people are given. How do you feel about this?

5. Is there anything that you would like to comment on or ask of me?

Interview Guide for Aboriginal Support Worker

1. Tell me about the patients that you work with in the hospital.

2. Tell me about your work with patients in the hospital.

3. Tell me about your experiences working with nurses in the hospital.

4. Tell me what it is like to work at this hospital.

5. Is there anything else that you would like to comment on or ask of me?
Interview Guide for Health Care Administrator

1. What are the most pressing concerns for First Nations women in the hospital and their families?

2. What do you see as the most pressing issues for nurses working in the hospital?

3. How could the hospital and overall health care services be improved for First Nations people in the region?